Philip Harms/Deep Roots Therapy PC is working as an independent contractor with
North Cherry Creek Counseling Center located at 2616 W. Alamo Avenue, Littleton, CO 80120
Telephone: 720-441-5152
deeprootstherapy@gmail.com

Intake Packet (Child, 10-14)

Welcome!

Your counselor at DEEP ROOTS THERAPY, P.C./Philip Harms, MA, LPC is honored to have the opportunity to work with you. This packet contains information and forms that your counselor will need to have on file for the first meeting.

Please review and complete the following documents:

1. Payment Policy Statement – to be reviewed and *signed.*
2. Client Information Form (Child) – to be completed and returned to counselor.

**All *signed* forms are to be returned to DEEP ROOTS THERAPY, P.C.

Please retain a copy of this information for your records.

DEEP ROOTS THERAPY, P.C.

The information provided in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better Philip Harms is able to assess your mental health needs. Please provide as much information as possible.

These forms should be filled out by the Parent(s) or Legal Guardian(s) consenting to mental health services for the minor child listed below. For purposes of mental health treatment in Colorado, a minor child is everyone that is under the age of fifteen (15) years old. The therapist at Deep Roots Therapy may interview the child and fill out the applicable sections or may request that the parent(s) or legal guardian(s) fill out the applicable section about their minor child. This is within the sole discretion of Deep Roots Therapy.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Payment Policy Statement

COMMUNICATION
Thank you for deciding to seek counseling at DEEP ROOTS THERAPY, P.C. The following information will help you understand many of the details about your therapy here. A primary commitment of DEEP ROOTS THERAPY, P.C. is to provide quality time-effective treatment to individuals, couples and families regardless of age, race, nationality, sex, or religious affiliation. Professional Christian counseling and the use of spiritual resources are available for patients who request it. Deep Roots Therapy will never impose its beliefs or values on its clients. DEEP ROOTS THERAPY, P.C and staff members are further committed to the patient's rights of information regarding office policies, non-discrimination, confidentiality, consent, and competent service. In keeping with this policy, we have listed below our various office policies for your information. Please read through these, ask any questions you may have, and sign on the other side. Thank you for allowing us to serve you.

You may e-mail your counselor for administrative purposes you may have (i.e. billing, appointments, etc.). After hours, leave a voice mail message with your contact information and you will be contacted by the end of the next business day. DEEP ROOTS THERAPY, P.C. is not a 24-hour counseling center and does not provide emergency services. If you are unable to contact your therapist at the telephone number he provided you, and you are having a true emergency, please call 911, check yourself into the nearest hospital emergency room, or call Colorado's Crisis Hotline (844) 493-8255. Deep Roots Therapy does not provide after hours service without an appointment. If you must seek after hour treatment from any counseling agency, center, and/or emergency room, you will be solely responsible for any fees due.

SESSIONS
Sessions are typically scheduled for 45-50 minute clinical hour instead of a 60 minute clock hour so that your counselor may review his notes and assessments on your behalf. The frequency of sessions shall be determined by the counselor and client. It is essential for you to feel comfortable with your counselor.

PAYMENT POLICY
DEEP ROOTS THERAPY, P.C. serves clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session. DEEP ROOTS THERAPY, P.C. charges $100.00 per forty-five to fifty (45-50) minute sessions. Our policy is for each person receiving counseling or testing services, including assessments, to pay for such service at the time the professional services are rendered. Any other arrangements must be mutually agreed to in writing and in advance of the session. A $25 administrative fee will be charged on all checks that are returned for non-sufficient funds. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that I may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that I may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, I will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. I will not disclose more information than necessary to collect the past due account. I will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

Phone consultations are billed in 15-minute increments ($30.00 minimum). All calls over five minutes will be billed accordingly.

Any additional work by a counselor, such as providing summary notes to a third party, will be billed at a prorated rate based on our current individual session rate ($100.00 or $2.00 per minute).

INSURANCE
Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company. DEEP ROOTS THERAPY, P.C. is an in-network, preferred provider with a number of health insurance carriers, and is an out-of-network provider for many others. Receipts for counseling services rendered are available upon request and may be used to submit for reimbursements if you choose.

If for any reasons, your insurance company, HMO, third-party payor, etc. does not compensate Deep Roots Therapy for therapy services rendered to you, you understand that you remain **solely responsible for payment**. Signing this Agreement permits Deep Roots Therapy to communicate with your insurance company, HMO, third-party payor, collections agency, or anyone connected to your therapy funding source regarding payments.

CANCELLATIONS
We understand that it may, at times, be necessary to cancel an appointment. To help us be most efficient and responsible in the use of our time, we require that any changes or cancellations be made at least 24 hours in advance of the scheduled appointment. Any missed appointment with less than 24-hour notice, excluding emergency situations, will be charged the full fee of $100.00. Any cancellations made with less than 24-hour notice, excluding emergency services, will be charged $50.00.

COURT FEES

DEEP ROOTS THERAPY, P.C. is qualified to provide expert witness in the realm of psychology and mental health in court upon request, and must respond to all court-summons/subpoenas, even if not testifying. Fees are paid ahead of time on retainer in 4 hour increments at $200.00/hour, point-to-point time. Uncharged time will be reimbursed to client following the service date. The Cancellation Policy applies for this service, and this fee is not covered by insurance policies. All court-related matters, whether as an expert witness or fact witness include but are not limited to: attorney fees your therapist may incur in preparing for the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time. The higher fee is $200.00 per hour.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

I authorize treatment of the person named below and agree to pay all fees as stated above.

_____ _____

Client/Parent/Legal Representative Signature **Date**

_____

Relationship to Client

_____ _____

DEEP ROOTS THERAPY, P.C./ Philip Harms, MA, LPC **Date**

Client Information Form (Child)

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better DEEP ROOTS THERAPY is able to assess your mental health needs. Please provide as much information as possible.

These forms should be filled out by the Parent(s) or Legal Guardian(s) consenting to mental health services for the minor child listed below. For purposes of mental health treatment in Colorado, a minor child is everyone that is under the age of fifteen (15) years old. The therapist at Deep Roots Therapy may interview the child and fill out the applicable sections or may request that the parent(s) or legal guardian(s) fill out the applicable section about their minor child. This is within the sole discretion of Deep Roots Therapy.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Child's Name: _____Birthdate: _____Age:_____

School:_____Grade:____Teacher:_____Counselor:_____

Parent/Guardian: _____
DOB: _____
Address: _____
City: _____
Zip Code: _____
Preferred Phone: _____
Voicemail Msg ok? _____
Email address:_____
Msg ok? _____

Parent/Guardian #2: _____
DOB: _____
Address: _____
City: _____
Zip Code: _____
Preferred Phone: _____
Voicemail Msg ok? _____
Email address:_____
Msg ok? _____

What is your preferred method of communication: □Telephone (H) □ Telephone/Text (C) □ Email

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and/or cell phones. By allowing DEEP ROOTS THERAPY to contact you by email you are consenting to receive electronic communications and understand the risks involved. DEEP ROOTS THERAPY cannot guarantee that confidential information shared using electronic communications will remain confidential.**

Marital Status of child's parents/guardians: (Please include the timing of any death, divorce, separation, civil union)

_____

_____

_____

If child's parents are no longer together, is either of the parents remarried: □ YES □ NO
Please list the child's Stepmother and/or Stepfather's Name and telephone number:

_____

_____
May DEEP ROOTS THERAPY contact any Stepmother and/or Stepfather: □ YES □ NO

LIVING ARRANGEMENT:

□ Both Parents □ One Parent □ Different according to time □ Guardian

Pertinent details:_____

Please list all family members or other people living in the child's home:

Name	Age	Gender	Relationship to child

Please list all other family or important people in your child's life:

Name	Age	Gender	Relationship to child

MEDICAL INFORMATION:

In order to provide your child with continuous and congruent care, DEEP ROOTS THERAPY may need to contact your child's primary care physician. Any contact that DEEP ROOTS THERAPY may have with your child's Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

***Physician Name: _____ Fax:_____ Phone:_____**

Please list any medication your child is currently taking (if your child is not currently taking any medications, please state that he/she is not currently taking any medications):

_____

_____

_____

Please list any current physical illnesses, issues, and/or ailments your child has (if your child does not currently have any physical illnesses, issues, and/or ailments, please state so):

_____

_____

_____

EMERGENCY CONTACTS: (please list name, phone numbers, and relationship to Client)

In case of an emergency, DEEP ROOTS THERAPY may be required to contact someone on behalf of your child if you are not available. Please list your emergency contact below, which DEEP ROOTS THERAPY may contact on your behalf. DEEP ROOTS THERAPY will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

(1) _____

(2) _____

Has your child been in therapy before? **No ____ Yes _____**

Therapist's Name(s) Dates Reason for Therapy

Outcome

_____

_____

_____

Date of Last Session: _____

May Deep Roots Therapy contact your child's previous or current Mental Health Provider**:** ☐ YES ☐ NO

Is your child currently in counseling with the above listed Mental Health Provider: ☐ YES ☐ NO

Any contact that DEEP ROOTS THERAPY may have with the above Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Have other family members been in therapy before? **No _____ Yes _____**

Therapist's Name(s) Dates Reason for Therapy

Outcome

_____

_____

_____

Please describe your reason(s) for seeking therapy for your child at this time:

_____

_____

_____

_____

Please circle any of the following that pertain to your child:

Nervousness	**Depression/Sadness**	**Angry/Aggressive**	**School Problems**	**Loss of Interest**
Eating Difficulties	**Shyness**	**Cries Easily**	**Self-Control**	**Fatigue**
Drug/Alcohol Use	**Headaches**	**Stomach Aches**	**Loneliness**	**Feeling Inferior**
Difficult to Discipline	**Legal Problems**	**Sleep Difficulties**	**Nightmares**	**Separation**
Difficulty with friends	**Attention/Memory**	**Suicidal Thoughts**	**Fears**	**Difficulty Relaxing**
Troubling Thoughts				

How has your child dealt with these issues/problems in the past:

_____

_____

_____

Has your child ever been, or are you currently, suicidal:

_____

Has your child ever attempted to commit suicide:

_____

Has anyone in your family ever attempted or committed suicide:

_____

Has your child used, or currently uses, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones):

_____

_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): □ YES □ NO

_____

_____

Please list major changes your child and/or family have experienced during the past five years:

(e.g. death (people or pets), moves, health changes, family changes, stress, trauma, school or job changes)

_____

_____

_____

Current Family Substance Use: (Include alcohol, marijuana, nicotine, prescription and non-prescription drugs)

_____

_____

_____

Are you or your child currently involved in any civil or criminal legal proceedings: □ YES □ NO
If yes, please state the circumstance(s):

_____

_____

Are there any weapons available or unlocked in your home:
□ YES □ NO □ Prefer not to Answer
If yes, please list the weapon, where it is located, and who it belongs to:

_____

_____

Do you or your child have a preoccupation with weapons, violence, killing, or fire:
□ YES □ NO □ Prefer not to Answer
If yes, please describe:

_____

_____

Client's Hobbies and Interests:

Does your child play any sports or musical instruments: ☐ YES ☐ NO

If yes, please list what sports and/or musical instruments your child plays:

_____

_____

Please list any other hobbies or interests that your child has:

_____

_____

How does your child normally spend his/her day? What does a typical day look like?

_____

_____

_____

_____

Other Information:

_____

_____

_____

Financial Information:

1. Will you need receipts for your insurance company: ☐ YES ☐ NO

2. Do you intend on a third-party (besides an insurance company) paying for counseling services:

☐ YES ☐ NO

If yes, please provide the following information:

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Relationship to Client: _____

3. Do you (parent or legal guardian) intend on paying for counseling services for your minor child on your own:

☐ YES ☐ NO

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE, AND CORRECT, TO THE BEST OF MY KNOWLEDGE:

_____ _____

Client/Parent/Legal Representative Signature **Date**

_____

Relationship to Client

_____ _____

DEEP ROOTS THERAPY, P.C./Philip Harms, MA, LPC **Date**