Hannah Milford, MA, LPC, LCDC, RPT
5716 West Hwy 290 #300 • Austin, TX 78735 • (512) 657-5893 • Hjmilford@gmail.com

Child Intake Forms

Child's Full Name: _____

Guardian's Name: _____

Client's Date of Birth: _____

Child's Address: _____

City, Zip Code: _____
(as given to insurance company)

Can Mail be Sent? ☐ Yes or ☐ No

Phone Number: _____

☐ Cell ☐ Home ☐ Work Can Messages be Left? ☐ Yes or ☐ No

Alternate Phone Number: _____

☐ Cell ☐ Home ☐ Work Can Messages be Left? ☐ Yes or ☐ No

Email Address: _____

Can Messages be Left? ☐ Yes or ☐ No

Emergency Contact Name _____

Emergency Contact Phone: _____

Health Insurance Information

********** The following is about who carries the insurance. **********

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's Address: _____

City, Zip Code: _____

(as given to insurance company)

Subscriber's Phone Number: _____

Insurance Company: _____

Subscriber ID: _____

Policy Group Number: _____

Authorization Number: _____

Number of Sessions Approved: _____

Do you have any Unmet Deductibles? ☐ Yes or ☐ No

Client's Relationship to the insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Client's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services (Hannah Milford, MA, LPC, LCDC, RPT, NCC).

_____

Signature Date

Child Intake Form

I appreciate you taking the time to fill out this form in its entirety. Your answers on the following pages will help me give you and your child the best possible care.

Reason for seeking counseling for your child:

Please list all current medications and prescribing physician:

Any previous counseling experience? If yes, list the reason for seeking therapy, dates and length of therapy and the name and phone number of the mental health professional who provided the treatment:

☐ Yes or ☐ No Has your child ever reported suicidal thoughts or an obsession with death? Describe:

☐ Yes or ☐ No Does your child display any other self-harm behaviors, like cutting, burning, picking, drug or alcohol use? Describe:

☐ Yes or ☐ No Has your child had any legal problems? If yes, briefly describe the cause for legal trouble and current status? Describe:

☐ Yes or ☐ No Family history physical or sexual abuse? Describe:

☐ Yes or ☐ No Family history of addiction or domestic violence? Describe:

☐ Yes or ☐ No Is the child being raised by someone other than their parents. Describe:

List everyone living in your home and any other significant family members:

Relationship	Name	Age	Comments

Are the child's parents divorced? _____Child's age at the time _____

Anything else you feel would be helpful for me to know in order to best care for your child?

To the best of my knowledge, the information provided is accurate and true.

Signature of custodial parent(s):

Name Date

Name Date

Child Custody Documentation

If a minor is to receive counseling from Hannah Milford, MA, LPC, LCDC, RPT, NCC and the minor is not living with both parents, the counselor needs proof that the parent or guardian bringing the minor to counseling has the legal right to seek counseling for the minor. IF this situation is true for you and your family, please attach the appropriate papers to this form and present it at the time of the first visit. The counselor will not see the minor without this documentation.

I understand that I must provide one of the following types of documentation at the initial evaluation to show that I have the legal right to bring this child/adolescent for treatment. I will attach the appropriate paperwork to this form:

- Divorce papers indicating I have sole custody and can seek counseling for this minor

- Divorce papers indicating I have joint custody and either of the parents can seek counseling for this minor without the other parent's consent

- Divorce papers indicating I have joint custody and both parents must agree or be notified if the minor is to receive counseling (if this is the case, both parents need to sign this form and the Consent for Treatment form)

- Guardianship papers indicating I am this minor's guardian and can seek counseling for him/her

_____

Printed Name

_____

Signature

_____

Relationship to Minor

_____

Date

HIPAA Notice of Privacy

Client Name:_____

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Private Health Information may be used and disclosed in the following circumstances:

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman's compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for any specialized government or military functions including active personnel, reservists, veterans, and discharged members of the military service. Also, for any person confined to a correctional institution or under any law enforcement supervision.
5. When used for any clerical purposes and necessary chart audits by managed care companies.

As a client, you have rights to your Private Health Information, including:

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your Private Health Information.
3. The right to receive confidential information regarding your private health information.
4. The right to revoke this consent in writing; however, this will not affect any Information already disclosed.
5.

As a private practitioner, I have the responsibility to:

1. 1.Make each client aware of the Privacy Notice.
2. 2.At any time make the necessary changes to the Privacy Notice that are required by law. If you as the client feel your privacy has been violated, you have the right to contact The U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/. I have reviewed and understand this notice.

_____

Signature of Patient or Personal Representative/Guardian Date

Disclosure & Confidentiality Agreement

About Hannah

Hannah Milford is a Licensed Professional Counselor, a Licensed Chemical Dependency Counselor, Registered Play Therapist and a National Certified Counselor. She is licensed and qualified to counsel in the state of Texas through the Department of State Health Services. Hannah earned her Bachelor's degree in Psychology with a minor in Sociology. She received her Master's degree in Professional Counseling from a CACREP accredited program at Texas State University.

Hannah counsels children, adolescents and adults with a multitude of issues, including child behavioral, parenting, addiction and abuse. Hannah adheres to the ethical standards of the LPC board and the International Association of Play Therapy.

Texas Department of Regulatory Agencies

The practice of licensed counselors is regulated by the Texas State Board of Examiners of Professional Counselors. The contact information for this agency is:

Texas State Board of Examiners of Professional Counselors
Texas Department of State Health Services
Mail Code 1982
P.O. Box 149347
Austin, TX 78714-9347
Email: lpc@dshs.state.tx.us
(512) 834-6658
www.dshs.state.tx.us/counselors/

My Responsibilities to You

Confidentiality:

With the exception of specific legal and training circumstances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not disclose to anyone what we discuss in session, or that you are even in counseling, without your written permission.

Legal Situations:

The following are legal exceptions to your right to confidentiality. Whenever possible, I would inform you if I have to put one of these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and or Adult Protective Services.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. If your record is subpoenaed in a court of law, I will do what I can to protect confidentiality within the limits of abiding by the law.

Your Records:

In the unlikely event that something should happen to me, (i.e. death or impairment), in which I am unable to continue counseling and unable to contact you, your records will be sent to Amanda Yoder De La Llata, MA, LPC. She is a counselor, working in Austin, who would contact you and provide an appropriate referral.

Use of Insurance:

If you choose to use insurance (see my website for updated insurance programs I currently accept), please know that insurance companies require me to provide a diagnosis for treatment. This information would be shared and discussed in session.

Your Responsibilities as a Client

Please be responsible for coming to your session on time and at the time we have scheduled. Sessions will be 45-50 minutes unless previously determined to be a different length. If you are late, we will end on time and not run over into the next person's session.

Please limit contact to counseling sessions you arrange with Hannah, except in the case of an emergency. If you are in need of emergency help at a time when your counselor is not available, it is your responsibility to call 911 or some other emergency service (such as 472-HELP, a 24-hour helpline). You may also go to the Psychiatric Emergency Services located at 56 East Avenue at Holly/River Streets (near IH-35 and the Colorado River). They provide in-person services from licensed professionals 24 hours a day, seven days a week, on a walk-in basis

Your Rights as a Client

1. You are entitled to information about my methods of therapy, techniques I use, the duration of therapy (if it can be determined), as well as my fee structure. Please feel free to ask if you would like to receive this information or if you have any additional questions.
2. You are entitled to seek a second opinion from another counselor or terminate counseling at anytime.
3. In a professional relationship (such as ours), sexual intimacy between a counselor and client is never appropriate and should be reported to the Complaints Management section of the Texas Department of State Health Services at 1-800-942-5540.
4. Confidentiality (please see above confidentiality section)

Payment

_____Client agrees to pay $_____ per session.

_____Client will be using insurance benefits to pay for sessions. Client agrees to pay any co-payments required. If anything changes with my insurance coverage, I will notify Hannah immediately and will pay for any sessions not covered by insurance.

Session fees are $100 per hour cash or check made payable to Hannah Milford. Sliding scale appoints may be available upon request; availability is limited. Payment is required when services are rendered. Clients (or guardians of minors) will be responsible for any insurance co-payment, deductibles, or unpaid claims. Any outstanding balance not paid within 30 days will be turned over to a collection agency for a recovery and a $50 collection fee will be charged to client's account. A $50 fee will be assessed for all returned checks payable to Hannah Milford.

Court

If records are requested for personal or for legal matters, client agrees to pay a $100 flat administration fee. Summary reports are available on request for $100 a report. If there are other costs associated with this service, (i.e. notary, postage), I agree to pay for that cost as well. This request must be made in writing via paper or electronically. If I request that Hannah participate in my legal matters, I agree to pay her full flat rate of $1,000 per day payable in advance to Hannah Milford. This includes but is not limited to testimony or being on 'stand-by' for testimony. Any cancellation of Hannah's scheduled appearance will require a 48-hour notice or prepayment will not be refunded. Insurance companies will **NOT** cover court appearances.

Cancellation Policy

Please allow 24 hours notice if you decide to cancel a session so that I have time to schedule others in your place.

Although I will take into consideration personal emergencies and extenuating circumstances, fees will still be charged for appointments missed without 24 hours notice. I also reserve the right to terminate therapy if cancellations or no-shows become excessive and are unable to be dealt with in the therapeutic relationship. I will discuss this with you prior to canceling services. Please be mindful of your time and mine.

Email

Email may be used for scheduling and informational purposes but not for emergencies. Please call 911 or another emergency service, such as 472-HELP, if you need immediate assistance. Although all considerable measures have been taken to ensure confidentiality of emails sent and received, please be aware of the risks taken when sharing personal or confidential information via email.

_____Initial

Ending Therapy

You have the right to terminate therapy at any time and you will typically be the one who decides when therapy will end, with the following exceptions:

1. If cancellations and no shows become an issue, as described above.
2. If I am not, in my judgment able to help you because of the particular concern you have, or because my training and skills are, in my judgment, inappropriate, I will inform you of this and refer you to another counselor who may meet your needs.
3. If you are verbally or physically violent toward me or threaten or harass me, I reserve the right to immediately discontinue your therapy. If I terminate your therapy I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I have read the preceding information and understand my rights and responsibilities as a client. My signature below acknowledges this understanding and indicates that I accept the conditions of counseling.

_____

Signature of Patient or Personal Representative/Guardian Date

_____

Signature of Patient or Personal Representative/Guardian Date