PCS
Pastoral Counseling Services

Counseling • Education • Consultation

2013 Elm Street • Manning House • Manchester, NH 03104-2528
Phone (603) 627-2702 • Fax (603) 627-3643 • Website pcs-nh.org
Satellite Offices in Bedford, Nashua & Portsmouth

NOTICE OF H.I.P.A.A. PRIVACY PRACTICES

Acknowledgment:

I hereby acknowledge that I received this Notice of H.I.P.A.A. Privacy Practices on _____20_____

Signed: _____
Client or Responsible Party

Please Print: _____

Please Print: _____
Responsible Party (if applicable)

PERSON TO CONTACT IN EVENT OF AN EMERGENCY:

NAME: _____

RELATIONSHIP: _____ TEL. NO: _____

REFERRED TO PCS BY: _____ RELATIONSHIP TO THIS REFERRAL:_____

ADDRESS: _____

MAY WE THANK THE PERSON WHO REFERRED YOU? Yes No

CLIENT INFORMATION FORM FOR CHILDREN (12 and under)

CHILD'S NAME:	DATE:
STREET ADDRESS (Required):	D/O/B:
P. O. BOX (if applicable): APT. # (if applicable):	SEX: M F
CITY: STATE: ZIP:	SSN:

PHONE: (Please include whose number it is, i.e.: Mom) OK to leave a message?

_____'s Home: _____ Yes No

_____'s Work: _____ Yes No

_____'s Cell: _____ Yes No

_____'s _____: _____ Yes No

EMAIL ADDRESS: _____

ETHNIC BACKGROUND: Native American/ Alaskan Native ___ Asian/Pacific Islander ___
Hispanic ___ Black/African-American ___ White/Caucasian ___
Other _____

REASONS FOR SEEKING COUNSELING AT THIS TIME: _____

HAS CHILD HAD ANY PRIOR THERAPY? YES __ NO__ WHEN? _____

WHAT WERE THE CIRCUMSTANCES? _____

THERAPIST'S NAME/PRACTICE: _____

FAMILY HISTORY:

FATHER'S NAME:			MOTHER'S NAME:		
MARRIED ( )	DIVORCED ( )	REMARRIED ( )	MARRIED ( )	DIVORCED ( )	REMARRIED ( )
LIVING ( )	DECEASED ( )		LIVING ( )	DECEASED ( )	
CAUSE OF DEATH (If applicable):			CAUSE OF DEATH (If applicable):		

FAMILY AND PERSONAL HISTORY (Continued):

	ADULTS LIVING IN THE HOME	NON-RESIDENTIAL ADULTS IN CHILD'S LIFE
BIOLOGICAL MOTHER		
BIOLOGICAL FATHER		
STEP-MOTHER		
STEP-FATHER		
ADOPTIVE MOTHER		
ADOPTIVE FATHER		
FOSTER MOTHER		
FOSTER FATHER		
OTHER (Please Specify)		

WHAT PLACE IS CHILD IN THE BIRTH ORDER? _____

SIBLING(S) NAME(S) AND AGE(S) (If you run out of room, please add additional siblings on back)	DOES SIBLING LIVE IN THE SAME HOME?	IS SIBLING CURRENTLY LIVING? If not, what are the circumstances of sibling's death?	BIOLOGICAL, STEP-, OR ADOPTED?

BRIEFLY DESCRIBE YOUR CHILD'S RELATIONSHIPS WITH:

FAMILY MEMBERS (Please indicate relationship with each family member rather than simply as a whole):

_____

_____

_____

OTHER RELATIVES (i.e., Grandparents, Aunts/Uncles, Cousins):

_____

_____

_____

PEERS:

_____

_____

_____

BRIEFLY DESCRIBE YOUR CHILD'S RELATIONSHIPS WITH: (Continued)

TEACHERS:

_____

_____

_____

OTHER ADULTS:

_____

_____

_____

MEDICAL HISTORY:

Any Pregnancy Complications?	
Any Delivery Complications?	

AT WHAT AGE DID CHILD:

Recognize caretaker (parent)?		Speak first recognizable word?	
Take first step?		Become toilet trained?	

LIST CHILD'S:

Past or Current Major Illnesses:			
Accidents:			
Hospitalizations:		When:	
Current Medication(s):			
Allergies:		Present Health:	

SCHOOL HISTORY (If Applicable):

CURRENT SCHOOL:	GRADE:
ADDRESS:	TELEPHONE NO:
TEACHER:	SCHOOL COUNSELOR:
DID YOUR CHILD HAVE A PRESCHOOL/KINDERGARTEN SCREENING? YES NO	
IS YOUR CHILD EXPERIENCING PROBLEMS AT SCHOOL? YES NO	
WHEN DID THESE PROBLEMS BEGIN?	
LIST THE PROBLEM(S) YOUR CHILD IS HAVING AT SCHOOL:	
WHAT HAS BEEN DONE BY THE SCHOOL TO RESOLVE THESE PROBLEMS?	

HAS YOUR CHILD BEEN EVALUATED FOR ANY OF THE FOLLOWING:

LEARNING DISABILITIES? **Yes** **No**	ATTENTION DEFICIT HYPERACTIVITY DISORDER? **Yes** **No**
ACHIEVEMENT AND/OR INTELLIGENCE TESTING PERFORMED BY THE SCHOOL OR BY A PSYCHOLOGIST? **Yes** **No**	
ANY OTHER SCHOOL OR PSYCHOLOGICAL TESTING? **Yes** **No**	IF YES, BY WHOM?

ALCOHOL AND DRUG USE HISTORY:

HAS YOUR CHILD EVER BEEN TREATED FOR AN ALCOHOL/DRUG PROBLEM?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S CURRENT USE OF ALCOHOL OR OTHER DRUGS?	Y	N
HAVE OTHERS EXPRESSED CONCERN ABOUT YOUR CHILD'S USE OF ALCOHOL OR OTHER DRUGS?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S ENGAGEMENT IN OTHER KINDS OF BEHAVIORS, SUCH AS OVEREATING, OR COMPULSIVE EXERCISING?	Y	N
DOES YOUR CHILD CURRENTLY USE TOBACCO PRODUCTS SUCH AS CIGARETTES, CIGARS, OR PIPE TOBACCO?	Y	N
DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S CONSUMPTION OF CAFFEINE, SUCH AS COFFEE, TEA, SPORTS DRINKS, OR SODA?	Y	N

CLIENT INFORMATION:

NAME: _____ DATE OF BIRTH:_____

RELATIONSHIP TO INSURED: SELF_____SPOUSE/PARTNER_____CHILD_____OTHER_____

SUBSCRIBER INFORMATION:

NAME OF SUBSCRIBER:	SUBSCRIBER S D/O/B:
ADDRESS (If different):	
SOC. SEC. NO. OF SUBSCRIBER:	
EMPLOYER:	
GROUP PLAN NAME:	GROUP NO:
PRIMARY CARRIER:	POLICY NO:
SECONDARY CARRIER:	POLICY NO:

METHOD OF PAYMENT (Place an / where appropriate)

	I will pay the full fee **each session**.
	Bill my insurance company for what I owe. I will pay **each session** any deductible and/or Co-payment and amounts in excess of my limits of coverage.

Make all checks payable to: PCS

We accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

PATIENTS OR AUTHORIZED PERSONS SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED DATE	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (INSURED OR AUTHORIZED PERSON) DATE

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AGREEMENT TO TREATMENT

I have received and reviewed with my therapist the following information:

Confidentiality

Professional Ethics and Complaints

Physical Exam

Emergency Coverage

Cancellations and Termination of Psychotherapy

Fees and Insurance Coverage

Photo Identification

I understand that pastoral counseling and psychotherapy are accepted approaches to treating emotional problems. In most cases, persons so treated receive benefit from the treatment. There may be risks associated with this treatment; the results are not guaranteed and depend on a number of variables.

CANCELLATION POLICY

Pastoral Counseling Services requires a 24-hour notice if you need to cancel an appointment. We cannot bill an insurance company for a missed appointment. The policy of the center is that the client will be charged for a missed appointment at the contracted rate allowed by your insurance company, up to $70.

Client: _____ Date: _____

Therapist: _____ Date: _____

Date: _____

INITIAL FEEDBACK FORM

As a means of monitoring and improving the quality of the care we provide, we would like to get some feedback from you about your first experiences at PCS. The information you provide will be used in our evaluation process and will remain confidential. After each statement, please circle the appropriate response:

1 = Strongly Disagree 2 = Disagree Somewhat 3 = Agree Somewhat 4 = Agree Strongly

1.	My initial phone call/email was responded to in a timely fashion.	1	2	3	4	
2.	The directions to PCS were clear and helpful.	1	2	3	4	
3.	I was greeted in a professional manner by the PCS staff.	1	2	3	4	
4.	The waiting room was neat, clean, and comfortable.	1	2	3	4	
5.	The information on the PCS forms was clear.	1	2	3	4	
6.	The information on the PCS website was useful.	1	2	3	4	N/A

Other Comments:

Name (Optional) : _____