GATEWAY CHILDREN'S MENTAL HEALTH SERVICES
515A WEST BUTLER RD., GREENVILLE, SC 29607

Date: ____________________ Medicaid ID: ______________________________________

Client's Name: ____________________________________ Birth Date: ____________________

Social Security Number: _____________________________

Guardian's Name(s): _______________________________ Relationship: __________________

E-mail: _____________________________________

Mailing Address: ____

____

Physical Address (if different) ____

____

Telephone #: Home __________________________ Cell/Other ___________________________

Do you give Gateway staff permission to leave a message on your phone(s)? Yes No

Religion: ___________________________________

Emergency Contact: Name ___________________________ Phone #: _______________________

Relationship to client: ____

Children – Name: ____________________________ Age: _______ Custody Status: ___________

Name: ____________________________ Age: _______ Custody Status: ___________

Name: ____________________________ Age: _______ Custody Status: ___________

Name: ____________________________ Age: _______ Custody Status: ___________

Others in the home – Name: ___________________ Age: _______ Relationship: _____________

Name: ___________________ Age: _______ Relationship: _____________

Reason for therapy: ____

____

Past Therapy services-when, where, reason: ____

____

Mental Hospitalization-when, where, reason: ____

____

Family members with a mental diagnosis-who and diagnosis: _____________________________

____

Have you ever been abused? Yes No Type? Physical, Sexual, Emotionally, Verbally, Neglect

MEDICAL INFORMATION-Describe any medical problems in the past or present that may be pertinent to know at this time (e.g. thyroid, seizures, cancer, diabetes, STDs, Hepatitis):

____

____

MEDICATION currently taking (type, dose, how often taken, what for): ____________________

____

____

____

ACTIVITIES INVOLVED IN: ____

____

SCHOOL ATTENDS & CITY ____

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DEVELOPMENTAL HISTORY

PRENATAL
Did Mom use alcohol while pregnant? Yes No Nicotine? Yes No Illegal drugs? Yes No

BIRTH (circle one)
Normal / Birth Trauma / NICU / C-section / Low birth weight / Premature / Other

INFANCY (birth to 2) (circle one)
Happy / Colic / Excessive crying / Overactive / Failure to thrive / Feeding issue

EARLY DEVELOPMENT (N=normal development, D=Difficult) (circle one for each)

Motor Skills	N D	Hearing	N D	Language	N D	Speech	N D
Vision	N D	Toilet training	N D	Cognitive	N D		

Any major losses/separations from family members/significant persons? Yes No
Describe ____
____
Other traumas-when and what: ____
____
____

SUBSTANCE ABUSE (if applicable):

Family's use in the past and present-who and substance? ______________________________
____
If you have used or currently use any of the substances below, please list how much, how often, and last use:
Alcohol ____
Marijuana ____
Sedatives (Benzodiazepines, Barbituarates) _____________________________________
Stimulants (Crack, Cocaine, Methamphetamine, Speed) ____________________________
Hallucinogens (LSD, Mushrooms, Mescaline) ____________________________________
Opiates (Heroin, Codeine, Morphine) ____
Inhalants ____
Steroids ____
Caffeine ____
Nicotine ____
Other ____

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OFFICE POLICIES

Welcome to Gateway Children's Mental Health Services. This document is to provide you with some very valuable information concerning legal and ethical responsibilities within this practice. Please read carefully and feel free to discuss any of these issues with the counselor.

Confidentiality – This document will describe how information about you may be used and disclosed and how you can get access to this information. Information shared during sessions will be held in the strictest of confidence. All information revealed in a therapy session, and most of the information placed in the therapy file, is considered "protected health information" by the Health Insurance Portability and Accountability Act (HIPAA). The protected health information is all medical records or other identifiable health information held or disclosed in any form (electronic, paper or oral). As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization, with exceptions, as defined below. Should you wish for me to confer with your physician, attorney, etc., you will be asked to sign a "Release of Information" form.

Use or disclosure of the following protected health information does not require your consent or authorization when:

1. Required by law, such as when the records are subpoenaed by a judge.
2. Endangerment, such as the duty to warn when someone is in danger of their life, getting help for someone who is a danger to themselves, child abuse, elderly abuse, etc.
3. Judicial and administrative proceedings, such as a case where you are claiming malpractice or breech of ethics.
4. Law enforcement purposes, such as when you claim mental health issues as a defense in a civil or criminal case.
5. Workers' Compensation, such as using your basic information obtained in therapy as a result of your Workers' Compensation claim.

Appointments – Your therapist may schedule their own appointments or the Receptionist will set your appointments. Your therapist will let you know. Appointments usually last 50 minutes up to 2 hours, depending on your mental health needs. Sessions may be weekly, twice a week, or monthly, depending on your mental health needs and availability of the therapist. If there's a life threatening emergency, call 911 or go to the nearest hospital. If a change in an appointment is needed, call as soon as you are able. Late cancelation is considered canceling less than 24 hours before your appointment. If you show a pattern of not showing to your appointment for two sessions without notification, or a pattern of late cancellation for two sessions, it will be determined by the therapist if services thru this office will continue. If it is determined that services will be discontinued, then the therapist will help you find other options to continue therapy services elsewhere.

Medicaid – This office will file claims on your behalf.

Activities asked of the counselor involving legal matters will be billed to your attorney or whoever requested the activities. Such activities include Deposition and court appearances. The charge is at the rate of $75.00 per hour. Please let your counselor know if these activities may occur.

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PAYMENTS AND INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

It is the policy of this office that all payments for counseling services be made at the time of your visit, and sometimes after in some cases. This payment is required regardless of who brings the child in to be seen. The responsible party is the legal guardian of the child.

- Initial________ (for Medicaid clients) I understand and agree that if Medicaid refuses to pay for my child's services or asks for paid services to be paid back to them (recoupment), then I will be responsible for those fees.
- Initial________ (for Medicaid clients) I understand and agree that if Medicaid shows in their system an insurance my child was under or currently under, I need to provide that insurance information to Gateway. Medicaid should then pay for services. If I don't provide the insurance information, I will need to pay a self pay rate of $100 per assessment and $75 per therapy hour.
- Initial________ (for all clients) If I need to pay the self-pay rate, I understand prices are subject to change and acknowledge receipt of the following self pay fees if I my child doesn't have Medicaid benefits or can't use their Medicaid benefits: intake/initial visit $100, follow-up visits $75. And if paying by personal check, if the check does not clear the bank properly and a fee is incurred, then the fee charged to you will be $35 and due before your child's next appointment start.

Signature (required): ________________________________ (legal guardian of client)
Print Name ____Date: ______________

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PROFESSIONAL DISCLOSURE STATEMENT
AND CONSENT FOR TREATMENT

Client's Name: ________________________Medicaid ID: ________________________________

I understand that my participation in individual, family, and/or group therapy is voluntary. I may terminate the therapeutic relationship at any time. I understand that all information shared is held in strict confidence and is released by my written permission to specific persons or institutions for specific reasons, except in special circumstances as specified in the Policies. These exceptions are mandated by state statute.

I have received and reviewed with a Gateway therapist the Office Policies document and understand its content. Under its terms, I further acknowledge that I consent to all counseling services provided by any Gateway counselor, assigned or reassigned counselor. I will seek treatment until such time as treatment goals are met or other reasons for termination of services have been specified. I understand that psychotherapy is a mutual relationship, which may be terminated by either party for specified reasons.

Everyone who participates in therapy must sign this document.

____________________________________	______________________________
Signature of Client or Guardian	Date

____________________________________	______________________________
Signature of Client or Guardian	Date

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I am completing this form to allow the use and sharing of protected health information about:

Client's Name ______________________________ Date of Birth _________________________

I authorize Gateway to bill for services to Medicaid.
I authorize (therapist) ________________________ to use or disclosed information which may include education, medical, psychological, psychiatric, and social data which might be helpful in further assessment and treatment of the client and for this purpose.

TO/FROM:

____
Relation: __________________________________
Phone/Address/Fax: ____
____

INITIAL & DATE below what you approve to be received or sent to the above listed place:

_______________ Psychotherapy Notes ______ Receive ______ Send
_______________ Medical Record ______ Receive ______ Send
_______________ Correspondence ______ Receive ______ Send:
_______________ Other ______ Receive ______ Send
Other Explanation: ____
____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires as described below.

This authorization will be continual unless a time frame is specified. Specification of the date, event or condition upon which this consent expires: ____________

____________________________________ ____________________________________
Signature and Relationship to Client Date

____________________________________ ____________________________________
Signature and Relationship to Client Date

____________________________________ ____________________________________
Therapist Date