GATEWAY CHILDREN'S MENTAL HEALTH SERVICES
1944 PEARMAN DAIRY ROAD, ANDERSON, SC 29625

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: _____
_____

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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 cash rate, which currently is $75.00 per hour. Please let your counselor know if these activities may occur.

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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 the therapist the Office Policies document and understand its content. Under its terms, I further acknowledge that I consent to and seek treatment with the therapist at Gateway 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