PRIVACY PRACTICES ACKNOWLEDGEMENT

MARRIAGE AND FAMILY COUNSELING CENTER
JANET M. EGGIMAN RN, MS, LMFT
614 W. Berry, Ste. C
FORT WAYNE, IN. 46802

I have received the Notice of Privacy Practices provided to me from Janet M. Eggiman and Marriage and Family Counseling Center on this date as required by HIPPA (Health Insurance Portability & Accountability Act.) I understand it is my responsibility to read it. I also understand if I have any questions, I may ask Janet Eggiman or the privacy officer about it.

NAME_____

SIGNATURE_____

DATE_____

MARRIAGE & FAMILY COUNSELING CENTER
JANET M. EGGIMAN RN, MS, LMFT
614 W. Berry, Ste. C
FORT WAYNE, IN. 46802

CONSENT TO TREAT A MINOR

I, _____ hereby authorize Therapist Janet Eggiman to evaluate and treat _____ as she deems necessary.

SIGNATURE_____ DATE_____

WITNESS_____ DATE_____

Marriage & Family Counseling Center

PATIENT INFORMATION

DATE_____

NAME_____ SSN#_____ DOB_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE_____ CELL PHONE_____ WORK_____
EMPLOYER_____ POSITION_____ FULL/PT
MARITUL STATUS MARRIED SINGLE DIVORCED OTHER
SPOUSE'S NAME_____ EMPLOYER_____
REASON FOR VISIT_____
NAME OF INSURED_____ DOB_____
INSURANCE ID #_____ or SSN_____
FAMILY PHYSICIAN_____ PHONE #_____
IN CASE OF EMERGNCY, WHO SHOULD WE NOTIFY?_____
(May we notify emergency contact? YES or NO) HOME PHONE_____
CELL PHONE_____
WHO MAY WE THANK FOR REFERRING YOU?_____

I hereby give permission to the therapist to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the therapist. I am financially responsible for non-covered services. If full payment of your account is made at the time of service, we will send payments directly to you or credit your account.

I hereby give permission to the therapist in the diagnosis and/or treatment of my consition as she deems necessary.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

SIGNATURE_____ DATE_____
(PATIENT/LEGAL GUARDIAN)

Marriage & Family Counseling Center
Janet M. Eggiman, RN, MS, LMFT
614 W. Berry Street, Ste. C
Fort Wayne, IN. 46802
Phone & Fax: 260-444-5034

Authorization for Release or Exchange of Information

Patient Name:_____DOB:_____
Information to Be Released By Or Exchanged With:

Name: _____

Address: _____

Phone: _____ Fax: _____
Information To Be Released By Or Exchanged:

___History and Physical ___Progress Notes
___Discharge Summary ___Diagnosis
___Psychiatric Evaluation ___Educational Tests
___Psychological Testing ___Lab Results
___Court/Agency Documents ___Treatment Plan
___Other_____
_____

The purpose of the use of this information is: _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____
I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____
I understand that this authorization will expire on __ __/__ __/__ __ __ __ Initials: _____
I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: _____

Signature of patient or patient's representative: _____Date: _____

Printed name of patient's representative:_____

Relationship to the patient:_____

Witness: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Marriage & Family Counseling Center

614 West Berry Street, Suite C
Fort Wayne, Indiana 46802
260-444-5034
jmeggi@yahoo.com

TREATMENT AGREEMENT

I, _____, hereby request evaluation and treatment from Marriage & Family Counseling Center.

I understand that medicine is not an exact science and that no guarantee can be made as to the success of treatment. I will insist on fully understanding the proposed treatment with its risks, benefits, and alternatives. I will unhesitatingly ask for a second opinion if I am in need of reassurance regarding the proposed plan of treatment. Once I agree to a plan of treatment, I will follow it to the best of my ability, and I will promptly notify from Marriage & Family Counseling Center of any unexpected effects.

I have received the Marriage & Family Counseling Center Notice of Privacy Practices. I understand that the minimum necessary medical information about me will be disclosed by from Marriage & Family Counseling Center for treatment, payment, and health care operations. I further understand that the from Marriage & Family Counseling Center Notice of Privacy Practices may change, and that I may request a new copy of the Notice of Privacy Practices from Marriage & Family Counseling Center at any time.

I have received a schedule of professional fees from Marriage & Family Counseling Center, and in consideration of the services to be rendered to me by Marriage & Family Counseling Center, I agree to be responsible for prompt, full payment of all fees regardless of third party liability. I am responsible for interest on my account balance at the maximum statutory rate and any applicable service fee. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at the time of service, or within 30 days of service, to pay reasonable collection fees incurred or any attorney fees and court costs if this account is placed in the hands of an attorney for collection, including collection costs.

If from Marriage & Family Counseling Center does not accept my insurance, I understand that fees are due as stated and are payable at the beginning of the assessment or evaluation session (this allows Marriage & Family Counseling Center to focus entirely on my problems, needs and concerns during the session). If Marriage & Family Counseling Center does accept my insurance, I understand that I am responsible for paying my co-pay/co-insurance/deductible amount at the time the service is rendered.

I agree to accept financial responsibility for any missed appointment/"no-show" and my insurance company will not be billed for nor reimburse me for missed appointments. To avoid paying the full fee for assessment, 24 hours advance notice is required to cancel or reschedule an appointment without incurring this full fee charge to my credit/debit card.

Accounts which are not settled within a 45-day billing period will be charged a monthly service charge of 10%

Marriage & Family Counseling Center is hereby authorized to release any necessary confidential medical information to my insurance company for the purpose of obtaining reimbursement for services provided, and my insurance company is authorized to pay Marriage & Family Counseling Center directly for said services.

I agree that my failure to fulfill my obligations under this contract will immediately relieve Marriage & Family Counseling Center, its employees, officers, directors, and shareholders, of further obligations to me.

_____

Signature Date

_____

Witness Date

Marriage & Family Counseling Center

614 West Berry Street, Suite C
Fort Wayne, Indiana 46802
260-444-5034
jmeggi@yahoo.com

PARENT/TEACHER CHECKLIST

STUDENT NAME_____GRADE_____AGE_____DATE:_____

Name of person completing form:_____ Relationship to student:_____

If Teacher, Contact information for questions_____

For each item, please circle a number to show how this student has been feeling, thinking, or behaving recently compared to peers.

DESCRIPTION	NONE	LITTLE	SOME	MUCH	VERY	WORSE
1. This student often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities	0	1	2	3	4	5
2. This student often has difficulty sustaining attention in tasks or play activities	0	1	2	3	4	5
3.This student often does not seem to listen when spoken to directly	0	1	2	3	4	5
4. This student often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not oppositional behavior or failure to understand instructions)	0	1	2	3	4	5
5. This student often has difficulty organizing tasks and activities	0	1	2	3	4	5
6. This student often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)	0	1	2	3	4	5
7. This student often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books or tools)	0	1	2	3	4	5
8. This student is often easily distracted	0	1	2	3	4	5
9. This student is often forgetful in daily activities	0	1	2	3	4	5
10. This student's hands or feet often fidget; or this student squirms in the chair or desk	0	1	2	3	4	5
11. This student often leaves their seat when they are expected to stay seated	0	1	2	3	4	5
12. This student often runs about or climbs excessively in situations when it is inappropriate	0	1	2	3	4	5
13. This student often feels restless in situations in which being still or quiet is appropriate	0	1	2	3	4	5
14. This student often has difficulty playing or engaging in leisure activities quietly	0	1	2	3	4	5
15. This student is often "on the go" or acts as if "driven by a motor"	0	1	2	3	4	5
16. This student often talks excessively	0	1	2	3	4	5
17. This student often blurts out answers before questions have been completed	0	1	2	3	4	5
18. This student often has difficulty waiting their turn	0	1	2	3	4	5
19. This student often interrupts or intrudes on others (e.g. butts into conversations or games).	0	1	2	3	4	5

TOTAL SCORE: _____

Marriage & Family Counseling Center

614 West Berry Street, Suite C
Fort Wayne, Indiana 46802
260-444-5034
jmeggi@yahoo.com

Child Clinician Intake Summary Form

Directions: This form is very important to help with our interview and evaluation process. Not all questions apply to all families; just answer questions as best as they apply to your family. Your answers will help us address your child's needs and understand him/her better.

Demographic Information

Child's Name:_____ Sex: M or F Child's Date of Birth:_____
Child's School:_____ Child's Grade:_____

Biological Father Information:
Name:_____ Age:_____ Marital Status:_____
Occupation:_____ Education:_____
Live with Child? Y or N (If no, how often does the child see this person?)_____

Biological Mother Information:
Name:_____ Age:_____ Marital Status:_____
Occupation:_____ Education:_____
Live with Child? Y or N (If no, how often does the child see this person?)_____

Other Male Caretaker: (Circle one: adoptive father stepfather grandfather mother's boyfriend other)
Name:_____ Age:_____ Marital Status:_____
Occupation:_____ Education:_____
Live with Child? Y or N (If no, how often does the child see this person?)_____

Other Female Caretaker: (Circle one: adoptive mother stepmother grandmother father's girlfriend other)
Name:_____ Age:_____ Marital Status:_____
Occupation:_____ Education:_____
Live with Child? Y or N (If no, how often does the child see this person?)_____

List everyone living in the house. Include all of the child's biological siblings whether in the house or not.

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who referred you for psychological services? _____
Do you agree with this referral? Yes No Mixed feelings

Presenting Problem

Please list the three biggest reasons (or problems) for which you are coming

1. _____
2. _____
3. _____

History of Present Problem

1. Approximately how old was your child when you first noticed your child's problem? What did the problem look like then?

2. How has your child's problem changed throughout his or her growth?

3. What is your child's attitude toward his or her problems?

4. Has your child had any other behavioral or emotional problems in the past (even if they are not affecting him or her now)? Describe them.

5. How many psychotherapists our counselors have you seen in the past for your child's problems? _____ Please list most current.

6. Has your child had any psychological or educational testing? Y or N If so, who did the testing?

7. Has your child ever talked about hurting or killing himself or herself or another person? Describe.

8. Has your child ever used or abused medication, illegal drugs, tobacco products, or alcohol? Describe.

Please check all that applies to your child

____ Chronic Lying
____ Stealing
____ Argues with adults
____ Bedwetting
____ Problems with the law
____ School refusal
____ Aggressive Outbursts
____ Temper Tantrums
____ Under or over eating
____ Self Injurious Acts
____ Easily Distracted
____ Fire Starting
____ Hurting Animals
____ Change in grades
____ Change in friends
____ Won't sleep alone
____ Easily annoyed
____ Angry
____ Irritable
____ Impulsive
____ Extreme worrier
____ Poor Concentration

Developmental History

1. Were there any complications during the pregnancy? If so, explain.

2. Were there any complications during delivery? If so, explain.

3. Please circle all that occurred during the mother's pregnancy.
   a. Smoking (# of packs per day____)
   b. Drinking alcohol (# of drinks per day____)
   c. Marijuana Use
   d. Cocaine; Crack use
   e. LSD use
   g. Physical abuse of mother
   h. Extreme stress on mother
   i. Major illness of mother
   j. Major injury of mother
   k. Regular prenatal care
   f. Other street drug use (what drugs:_____)

4. Birth History:
   Weight _____ Type of birth: Vaginal____ C-Section____
   Premature birth? Y or N If so, how many weeks premature?_____
   Problems/illness immediately after birth:_____

5. At what age did you child:
   Sit:_____ Say first word:_____ Say two word sentence:_____
   Crawl:_____ Toilet trained:_____
   Walk:_____ Learned to read:_____
   Would you say your child developed faster, slower, or at about the same rate as other children?
   _____

6. Circle all that apply to your child as a baby:

Cuddly	Curious	Difficult to soothe	Easy to put on a schedule
Irritable	Active	Withdrawn	Easily startled/overactive
Cried a lot	Good sleeper	Friendly	Slow to warm up
Tense/on edge	Afraid of strangers		

Medical History

1. Current medications:

Name	Dose	Reason
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		
7._____		

In your opinion are these medications helping?

Are there any adverse side effects?

Has your child ever been on psychotropic medications? If so, what?

2. Drug allergies: Y or No If so, what? _____
3. Child's immunizations up to date? Y or N
4. Has your child had any hospitalizations or surgeries?
5. Has your child ever had any serious and/or life threatening illness or injuries?
6. Height_____ Weight_____

Family History

Does anyone in the child's immediate or extended family have the following illnesses or problems? Include brothers, sisters, father, mother, grandparents, aunts, uncles and cousins.

Illness	Circle Y or N	Relationship
Depression	Y N	_____
Manic Depression	Y N	_____
Nervous Breakdown	Y N	_____
Psychiatric Breakdown	Y N	_____
Delayed Reading	Y N	_____
Delayed Speech	Y N	_____
Mental Retardation	Y N	_____
Attention Problems	Y N	_____
Hyperactivity	Y N	_____
Heavy Drinking	Y N	_____
Drug Abuse	Y N	_____
Suicide	Y N	_____
Stealing	Y N	_____
School Phobia	Y N	_____
Epilepsy	Y N	_____
Felony Conviction	Y N	_____
Anxiety Disorder	Y N	_____
Bedwetting	Y N	_____
Aggressive Outbursts	Y N	_____
Schizophrenia/Psychosis	Y N	_____
Autism	Y N	_____
Eating Disorder	Y N	_____
Insomnia	Y N	_____
Any Genetic Disorder	Y N	_____
Other	Y N	_____

1. Please indicate if the following have occurred in the family:

	Date	Description/Comments
Parental Divorce	_____	_____
Separation	_____	_____
Marital Problems	_____	_____
Domestic Violence	_____	_____
Excessive Conflict	_____	_____
Death of Parent	_____	_____
Death of Sibling	_____	_____
Death of Grandparent	_____	_____
Alcohol Abuse	_____	_____
Drug Abuse	_____	_____
Move to a new Home	_____	_____
Physical or Sexual Abuse	_____	_____
Significant Illness	_____	_____
Other Changes	_____	_____

2. How is discipline handled in the family?

3. Who is most responsible for discipline? Mother Father Both

4. Ethnicity/Church/Spirituality:
   Ethnic Origin: _____
   Ethnic Issues: _____
   Religious Affiliation: _____
   Level of Religious Activity: _____

5. Recreational and Leisure Activities:
   Is your child involved in any community activities, sports, groups or lessons?

   Does your child have any hobbies or special interests?

6. What do you see as your child's strengths or special abilities