Family Service Agency

Strengthening Individuals & Families

Hello,

Attached is the Child Intake paperwork required to start services with us. Also attached is the Authorization to Release Information; we will need you to complete one for your child's school. If your child is over the age of twelve, they will need to complete another Authorization to Release Information for the parent for the clinician to share any information with you regarding their counseling. When you've completed the paperwork, please return it with a copy of your driver's license/ID (front and back), a copy of your child's insurance card (front and back), and proof of income. As Medicaid providers, Medicaid requires us to have proof of income in the file.

The Acknowledgements forms can be accessed by utilizing the below QR code or upon request. These forms are for your information; they do not need to be returned.

If you have any questions, don't hesitate to contact me at the number below.

Thank you,

Shatoya Jackson, MSW, LSW
Director of School-Based Programming
Pronouns: She/Her/Hers
P: (815) 758-8616 Ext. 1204
F: (815) 758-7569
Email: sjackson@fsadekalbcounty.org
www.fsadekalbcounty.org

Family Service Agency
Strengthening Individuals & Families

CFC Group Services Consent Form

Dear Parent/Guardian:

Your student's school is teaming with Family Service Agency during regular school hours to provide counseling and support services in a group setting or individually. These services are coordinated through the Student Services staff but are provided by the Family Service Agency. The goal of school-based services is to provide counseling in a setting that is familiar to students, particularly those who are not able to access services through traditional means.

Please complete the following information for your child to participate in FSA services and/or programming through the school.

School:_____ Group:_____

Name: _____ D.O.B._____

Age:_____ Grade:____ Gender:_____Race:_____ Ethnicity:_____

Preferred Name: _____

Primary Contact Person:_____

(Name and relationship to student)

Primary Phone: _____

Email Address:_____

Address: _____ City: _____ Zip:_____

Alternate Contact Person/Phone: _____

(Name and relationship to student)

Signed:

_____

Parent/Guardian Name / Date

_____

Child – Age 12 & Above - Name / Date

_____

Witness Name / Position / Date

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Strengthening Individuals & Families

Consent for Counseling

Part 1: General Information

The Family Service Agency (FSA) provides group counseling services to DeKalb County youth ages 8-18 and their families. Our mission at FSA is to assist DeKalb County youth to build healthy lives and responsible relationships with family, friends, and the community. Our goal is to provide caring and professional services for our clients.

FSA employs professionally trained counselors with graduate degrees in psychology, counseling, or marriage and family therapy. In addition, Master's level candidates completing their practical experience requirements are also on staff at FSA, and may be involved with, or serving as, your counselor. These interns are highly competent and will be working under the direct supervision of a clinical supervisor as well as a team of experienced youth and family counselors.

Groups – FSA offers several specialized groups that seek to meet goals specific to the overall purpose of each group. Individuals may benefit a great deal during the group process by resolving specific concerns brought to the group. In working to achieve any potential benefit, group activity will require that a firm effort be made to change, and youth may experience discomfort. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Center for Counseling (CFC) The Center for Counseling offers individual and family counseling to youth, individuals, and families of all ages. We believe everyone deserves to be supported in making positive changes in their lives. In addition, youth can be referred for a comprehensive assessment to determine if additional services are needed.

Part 2: Your Rights as a Client

1. Confidentiality: Within the limits of the law, information revealed by you will be kept strictly confidential and will not be revealed to any other person or agency unaffiliated with FSA without your written permission. We routinely staff our cases during clinical supervision and team consultation to assist counselors in improving skills and in planning for future sessions. These meetings will be kept strictly confidential.

a. If you are participating in a group, you are expected to maintain confidentiality regarding other group member's disclosure of personal information.

2. Illinois law and ethical practice require us to notify appropriate state agencies without your permission if (a) we suspect or know of a child or elder abuse/neglect situation, (b) you threaten bodily harm or death to another person or yourself, or (c) a judge issues a court order requesting relevant information. If you have concerns about any of the above-stated conditions regarding confidentiality, please discuss them with your counselor.

3. You have the right to end counseling at any time without any moral, legal, or financial obligations to FSA other than those already accrued. If you wish to terminate the relationship, we ask that you contact FSA by phone or in-person to inform us of your decision.

4. All paperwork and files are property of FSA and maintained by the agency, not the school.

5. The Family Service Agency ensures that counselors meet all professional standards and maintain their own liability insurance.

6. There is no charge to families for school-based services. By signing the bottom portion of this letter, you give permission for your student to participate in the school-based counseling service. The signature will also serve as permission for your child's school to facilitate a referral and follow-up with the Family Service Agency.

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PHOTOGRAPH & VIDEO RELEASE

I hereby authorize Family Service Agency and those acting pursuant to its authority to photograph, video tape or use any other electronic method of recording my likeness and/or voice to be used in the Agency's discretion. The above mentioned might be used in, but not limited to, newsletters, web site, newspaper or other media, or any other outlets deemed appropriate by Family Service Agency. These photographs and/or video footage will not be digitally manipulated to change its content.

I give Family Service Agency the right and permission, without restrictions, to make, copyright, and/or use, re-use or publish said photographs/video footage of me in which I may be included I whole or in part and waive any right to approve the finished printed materials, videos and/or web sites where my image appears. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I release Family Service Agency and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of the Family Service Agency.

I waive any right to compensation for my appearance in printed documents, videos or web sites in any and all future used of the photographs and/or video footage.

There is no expiration date to this release.

I have read and fully understand the terms of this release.

_____ _____

Printed Name Date

_____

Signature (Individual or Legal Guardian)*

*Individuals under 18 years of age must provide the signature of their Legal Guardian.

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Child Intake Form

Child's Name: _____ Birth Date: _____
Last *First* *MI* *MM/DD/YYYY*

Child's Preferred Pronouns: _____ Child's Preferred Name: _____

Guardian Information

Primary Guardian: _____ Birth Date: _____
Last *First* *MI* *MM/DD/YYYY*

SSN: _____ Cell phone: _____ Home phone: _____

Email: _____

Address: _____
Street Address *City* *State* *Zip Code*

Employer: _____ Phone: _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ Email Best Time to Contact: _____

Secondary Guardian: _____ Birth Date: _____
Last *First* *MI* *MM/DD/YYYY*

SSN: _____ Cell phone: _____ Home phone: _____

Email: _____

Address: _____
Street Address *City* *State* *Zip Code*

Employer: _____ Phone: _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ Email Best Time to Contact: _____

Custody Arrangement: ☐ Married ☐ Joint Custody ☐ Shared Custody ☐ No Arrangement (never married)
☐ No Arrangement (divorced) ☐ Other:

Demographic Information

Child's Race: _____ Language(s) Spoken *(**Primary first):* _____

Is child of Hispanic, Latino/a/x, or Spanish origin? ☐ Yes ☐ No

If yes, please check one: ☐ Mexican/Mexican American ☐ Puerto Rican ☐ Cuban ☐ Central or South American
☐ Other ☐ Unknown

Child's Current Grade Level: _____

Citizenship Statue: ☐ U.S. Citizen ☐ Non-U.S. Citizen

Do you require an interpreter? ☐ No ☐ American Sign Language ☐ Foreign Language _____

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Financial & Household Information

Household Size: _____ Household Income: $_____ Client Income: $_____

	Insurance Co.	Policy #	Group #
Primary Insurance			
Secondary Insurance			

Primary Insurance Holder: _____
First Name *MI* *Last Name*

SSN: _____ Birth Date: _____ Phone Number: _____

Mailing Address: _____
Street Address City State Zip Code

Email Address: _____

Place of Employment: _____

Secondary Insurance Holder: _____
First Name *MI* *Last Name*

SSN: _____ Birth Date: _____ Phone Number: _____

Mailing Address: _____
Street Address City State Zip Code

Email Address: _____

Place of Employment: _____

Children living in the household:

Last Name	First Name	Age	Gender	Relationship to Client

Others living in the household:

Last Name	First Name	Age	Gender	Relationship to Client

Treatment History

Is the client currently or previously receiving mental health treatment? ☐ Yes ☐ No

If yes, where? _____ Are you willing to sign a release of information? ☐ Yes ☐ No

Is the client on any medications? List below. ☐ Yes ☐ No

Name of Medication	Purpose of Medication	Dosage	Effective?

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Recent health problems and/or hospitalization(s)? Please list below.

Date	Concern	Other

Do you have concerns about any of the following? *(Check all that apply)*

- ☐ Anger Management
- ☐ Anxiety
- ☐ Sexual Behaviors
- ☐ Severe Mood Swings
- ☐ Eating Problems
- ☐ Fears
- ☐ Hyperactivity
- ☐ Behavior Changes
- ☐ Sleeping Problems
- ☐ Depression
- ☐ Alcohol/Drugs
- ☐ Problems at School
- ☐ Other

Person completing this form: _____ Date: _____

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Child Symptom Checklist

Name _____ Date _____

Please indicate below if you experience any of the following and how often within the last 3 months.

M=Most of the time S= Sometimes N= Never

Symptom	M	S	N	Symptom	M	S	N
Feelings of guilt				Trouble concentrating			
Worrying				Impulsivity			
Anger				Overly tired			
Problems falling asleep				Over eating			
Problems staying asleep				Bingeing/Purging			
Phobias/fears				Food preoccupation			
Feeling alone				Less interested in school			
Stealing				Sleeping too much			
Trouble making decisions				Hearing voices			
Mood changes for no reason				Bullying			
Restlessness				Fights with other children			
Does not respect rules/authority				Grades dropping			
Hopeless about the future				Thinking about death			
Ruminating about the past				Thinking about suicide			
Crying excessively				Feeling down or blue			
Shortness of breath				Obsessive thoughts			
Irritable or on edge				Impatient			
Alcohol misuse				Nightmares			
Drug abuse				Afraid of new situations			
Self-injurious behaviors				Physical abuse to others			
Lying				Sexual acting out			
Uncontrolled thoughts				Hyperactivity			
Uncontrolled behaviors				Other:			

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Consent for Services & Financial Agreement

Consent for Services

I, _____, request services from Family Service Agency's Programs:
(Client)

- Center for Counseling
- Child Advocacy Center
- DeKalb County Community Action
- Senior Services
- Youth Mentoring

I, _____, request services from Family Service Agency's Programs.
(Parent/Guardian)

1. I seek and consent to participate in services at Family Service Agency's programs.
2. I understand that developing a treatment plan with my counselor and regularly reviewing progress toward my treatment goals is in my best interest.
3. I understand that I may stop program services at any time and that I am responsible for any consequences of terminating counseling.
4. I understand that when services terminate *Agreement to Pay for Professional Services* continues to apply until my bill is fully paid.
5. I understand that my insurance company or third-party payer may receive information about the services I receive.
6. I understand and have discussed with my counselor: a) my condition, problem and/or diagnosis, b) the planned course of treatment, c) alternatives to treatment, including no treatment and d) confidentiality and the limits or exceptions of confidentiality.
7. I understand as the parent or guardian of a recipient of services who is at least 12 but under 18 years of age that my child has rights to confidentiality that are different than for a child under 12years of age, I understand the following provisions;
    a. Any minor 12 years of age or older may request counseling services without the consent of the parent or guardian.
    b. Sessions provided to a minor age 12-17 without parent or guardian consent shall be limited to not more than 7 sessions, lasting no more than 45 minutes each.
    c. If a minor child age 12-17 chooses to consent to counseling without parent or guardian consent then the parents will not be informed unless required by law.
    d. If a minor child age 12-17 chooses to consent to counseling without parent or guardian consent then the parents are not financially responsible for those sessions.
    e. Parent or guardian is not entitled access to protected health information of a child age 12-17 without the child's consent, unless required by law.
8. If the person to receive services is a minor (under the age of 18 years of age) I give permission to the program services to provide services to him or her.
9. I understand that a child age 17 or under who has been a victim of criminal sexual assault or abuse may consent to program services without parent or guardian consent.
10. I give consent for Family Service Agency to contact me for evaluative purposes.

Agreement to Pay for Professional Services

I, _____ , agree to pay the fee(s) described for these services and any additional fees described below or to pay the fee negotiated by the insurance company, Employee Assistance Program, employer, financial assistance scholarship, or third-party payer.

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Charges that may apply:

- The fee for intake or diagnostic assessment is $150.
- An individual session costs up to $150, depending on type of session and time frame of session.
- Sessions extended more than 10 minutes are charged on a pro-rated basis for the additional time.
- If I seek additional services (i.e. requesting materials for court, seeking a counselor in court) I will be charged the hourly rate of $90 for those services.
- The fee for mediation is $125 per hour which is divided equally between each party.
- The fee for phone consultation with a counselor is pro-rated based on the hourly rate of $90.
- The fee for checks returned for insufficient funds is $25 per occurrence, plus any applicable collection fees.
- If I fail to cancel an appointment less than 24 hours in advance or no show I will be charged a $25 fee.

Additional billing policies:

- I am responsible for knowing my insurance benefits and for providing accurate and timely insurance information, including completion of any authorization or approval process required by my insurance company. Any fees not covered by my insurance company resulting from not knowing benefits or providing accurate or timely information is my responsibility.
- There are some services that insurance may not cover and I am responsible for these fees or any fees denied for coverage by my insurance.
- If my insurance or other third party payer has not paid for services after two billings or denies coverage, I am fully responsible for the remaining bill for services.
- If a bill is not paid it may be sent to collections and I will be responsible for the additional 35% charged by the collection agency to collect the bill.
- I am responsible to give the Family Service Agency updated address information. Failure to do so may result in any unpaid bill being sent to collections.
- Lack of payment of the co-pay for two consecutive sessions or lack of timely payment on a pre-arranged payment plan may result in being unable to schedule another appointment with a counselor until payment is received on the account.
- Any billing questions should be directed to the Family Service Agency Business Office.

If you have additional concerns, please contact the Agency for assistance 815-758-8616.

I understand and agree to the information contained in the *Program Services* and give informed and willing consent to receive these services from Family Service Agency for myself or for the minor named above.

I understand and agree to abide by the policies contained in this Agreement to Pay for Professional Services. If applicable, my signature below authorizes my insurance to make payment directly to Family Service Agency's Center for Counseling.

Client Name (Printed)	**Date**
Client Signature	**Date**
Facilitator Signature	**Date**

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Consent to Participate in Telehealth Appointments

I, _____ understand:

- My behavioral health professional wishes me to engage in a telehealth consultation using Doxy.me.
- My behavioral health professional has provided information needed to make an informed decision about engaging in Doxy.me technology.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that my behavioral health professional or I can discontinue the telehealth consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.
- I understand that if others are present during the consultation other than my behavioral health professional, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth session/room: and or (3) terminate the consultation at any time.
- In an emergency, I understand that the responsibility of my behavioral health to contact my listed emergency contact or the local first responders if there is a termination of the Doxy.me video conference connection.
- I have had a direct conversation with my behavioral health professional, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

Please indicate your preference below.

☐ I have had the alternatives to a telehealth consultation explained to me and I am choosing to participate in a Doxy.me telehealth consultation.

☐ I have had the alternatives to a telehealth consultation explained to me and I am choosing **NOT** to participate in a Doxy.me telehealth consultation.

By signing this form, I certify:

- I have read or have had this form read/explained to me.
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

Client Signature	Date
Parent/Guardian Signature (If applicable)	Date
Provider Signature	Date

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Family Service Agency Client Acknowledgments

Client Name: _____
Last *First* *MI*

Primary Guardian: ***(If applicable)*** _____
Last *First* *MI*

Mandatory Documents

- Notice of Privacy Practices
- Client Rights and Responsibilities
- Behavior Support and Management
- Client Grievance Process

Mandatory documents can be found by scanning the QR code located at the bottom of this page or by request from reception or designated clinician.

I acknowledge that I was given the above documents for review and offered a copy for my records. I understand and agree with the terms of these documents. I understand that I may request additional copies at any time.

Client Signature (or Parent/Guardian for child under 18)	Date
Client Signature (or Parent/Guardian for child under 18)	Date
Client Signature (Child 12 years of age or over)	Date
Staf Signature	Date

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