Confidential Information for Children & Adolescents
David W Roper, MS, LPC

Today's date: _____

Child's Name _____ Date of Birth / Age: _____

Address: _____

Email _____ His/her cell _____

Parent's Name _____ Date of Birth / Age: _____

Address: _____

Email _____ Cell _____

Occupation _____ Employer _____

Parent's Name _____ Date of Birth / Age: _____

Address (if different from above): _____

Email _____ Cell _____

Occupation _____ Employer _____

Step-Parents' Name _____ Date of Birth / Age: _____

Email _____ Cell _____

Occupation _____ Employer _____

Step-Parents' Name _____ Date of Birth / Age: _____

Email _____ Cell _____

Occupation _____ Employer _____

Other children's name(s), age(s) & who they live with: _____

_____

_____

Custody

If this child is named in a custody agreement or court order, Texas law requires that I have a current copy of the custody agreement or court order, as well as any applicable divorce decree, in my records. Please provide this information at your first appointment.

Referral Information

Who referred you to me? _____

Why are you seeking counseling? What brought on this request for counseling and what do you hope we can accomplish? _____

_____

_____

_____

Who will need to change for this to occur? _____

How many months do you think this may take (your best guess)? _____

Mental Health History

Regarding this child/adolescent, please list <u>any</u> previous mental health contact (counselor, psychologist, psychiatrist, hospitals), with whom, when and why?

_____

_____

_____

Please list any pertinent mental health counseling for any other family members _____

_____

Medical History

Please list any significant medical problems this child has _____

_____

Medications he/she is taking and why _____

_____

List significant medical problems in the family _____

_____

_____

Other Key Information I Need to Know

_____

_____

_____

Informed Consent

Please initial in the spots below.

Below are some important facts regarding treatment. If you have any questions, please raise them at your initial appointment and/or before you sign this.

Payment of Fees, Duration of Sessions, Cancellation Policy, etc

_____ My counseling fee is $140 per hour. (I do have a sliding fee scale if you are in need, that is, if you earn less than $75,000 gross family income annually, you may pay $120/hour. If you earn less than $50,000 gross family income annually, you may pay $100/hour. Talk to David at your first session if you would like to request this sliding fee scale.)

_____ Most sessions last about 60 minutes, however, I offer my clients additional time as needed to allow my clients time to finish discussing their issues. If your session lasts beyond 60 minutes, each additional 1/4 hour is an additional 1/4 of a session fee (i.e., if paying the $140/ hour rate, then a 1¼ hour session would be $175; a 1½ hour session would be $210). Payment via cash, check, credit card, Venmo or PayPal is expected at the conclusion of each session.

_____ My sessions typically start on time; as such if you are running late, that is fine but note that you are missing out on time for which you are being charged. On occasion, I may run 5-10 minutes late starting your session; if that occurs, I will add 5-10 minutes on to give you your full time.

_____ Brief (5 minute) contacts made via phone, text or email will not incur a charge, however, extended communication (10-15 minutes or beyond), meetings/contacts with outside persons or agencies (psychologists, psychiatrists, counselors, schools, family members, etc.), if needed, will incur a charge as noted above. Meetings like this with outside agencies will be discussed with the client (or parent/legal guardian if the client is under 18 years of age) ahead of time to discuss the need for such a meeting and will require verbal approval by the client/parent/legal guardian.

_____ Initial here that you understand and agree that under no circumstances may the sessions, consultations or phone calls be recorded via any means.

_____ If you need to cancel an appointment, notify David Roper via phone (210-215-7945) as soon as possible. Cancellation within 24-hours or a missed appointment without a 24-hour notification will be charged as a regular one-hour session.

_____ I don't take insurance. If you would like to file with your insurance company, you may do so. You "may" be able to receive partial reimbursement towards your "out of network" deductible by doing so. If you'd like to do so, just ask me; I'll provide the information for you.

_____ It is my strong preference to not be involved in legal matters. If you become involved in legal proceedings that require my participation, even if I am called by another party, you will be charged at a rate of $250/hour for any work performed by me relating to this legal matter (phone calls, emails, report writing, photocopies made, appearing in court whether I testify or not, etc.).

_____ Occasionally, we may communicate with each other via text messages, phone calls, emails, Facetime, Skype, etc. You need to be aware that these methods of communication are not 100% confidential. Initial here to denote that you understand this and are okat that we may communicate occasionally via text, email, phone, etc.

_____ Text me (210-215-7945) when you arrive in the waiting room so I know you're here.

_____ I give my consent for David Roper, MS, LPC to provide counseling services to my/our child. These services will include an initial interview/intake. If at the end of the first visit it is recommended that my/our child will continue in counseling with David Roper, I/we give permission for him to provide these services.

Confidentiality

All information and records will be kept confidential in accordance with state laws regarding confidentiality of such records and information. (If this counselor dies or becomes incapacitated, the executor of his will shall maintain custody of these records.) Because privacy/confidentiality is crucial to the success of treatment of minors, I request that parents of children 18 and under consent to give up their access to their students' records. Note that records and/or information WILL be released regardless of consent under the following circumstances:

Abuse/ Neglect	According to state and local laws, therapists must report suspected abuse to the appropriate agencies in all cases of abuse or neglect of minors or the elderly.
Suicide risk/ Homicide risk	According to state and local laws, therapists must report to the appropriate agencies and/or parents all cases in which there exists a danger to self or others.
Consultation	On occasion, I may consult with / seek the thoughts of another professional regarding your case. If I do so, you will not be charged and no information will be disclosed that exposes your identity.
Insurance	When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.
Medical Need	In the event that a client is in need of emergency services and other medical personnel need to be contacted.
Court Order	If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.

Emergency On-Call Services

If you are in need of emergency services, please contact 911or the nearest hospital emergency room. On occasion, I can be reached by cell phone at 210-215-7945 but I am not "on call" 24 hours a day, 7 days a week.

Complaint / Grievance

If you have a complaint, please speak to me about it. If you wish to file a grievance, write to "Complaints Management & Investigative Section", PO Box 141369, Austin, TX 78714-1369.

I have read and understand the statement of Informed Consent. I consent to treatment by David Roper, LPC with the knowledge of the above conditions.

_____ _____
Signature (Parent/Guardian) Date

_____
Printed Name

_____ _____
Signature (Child / Adolescent) Date

_____
Printed Name

Payment Authorization

I authorize David Roper to utilize this credit card to make payments for counseling services (counseling sessions, no shows, etc.) for myself and members of my family unless noted differently below. If I wish to revoke this authorization, I will do so in writing by emailing David Roper at davidroper.ms.lpc@gmail.com and any future counseling session payments would not be authorized.

_____ _____
Signature Date

_____ _____
Printed name Email address for receipt

_____ _____
Credit card number Month / year of card expiration

_____ _____ _____
3 digit code Zip code for card Name on credit card

_____
Name(s) of person(s) primary involved in counseling