PERMISSION TO PROVIDE
MENTAL HEALTH/COUNSELING SERVICES TO A MINOR

By my signature below I verify that I am the parent and/or legal guardian of the minor (name):

____

DOB

____

and have the legal authority to seek mental health and counseling services for him/her. I hereby grant:

MARTIN COUNSELING, PLLC
And any therapist affiliated with this entity

permission to provide these services for my child. I further understand that according to Texas law both parents have equal access to all medical and mental health records of a minor child, unless specifically prohibited by law. Therefore, all medical and mental health records will be released upon request to a legal parent, guardian, or authorized representative of this minor child. I understand that Martin Counseling does not provide a forensic evaluation. I understand that Martin Counseling does not make recommendations about placement of a child for custody disputes and does not provide investigation or reassessment to reach a determination about child abuse or custody.

Signature: Date:

____

Print name:

____

MARTIN COUNSELING, PLLC

We are honored by your decision to seek assistance from our Counseling Services. Your response to this form will serve as a brief and helpful introduction. All submitted information is confidential. If an item does not relate to you, write "NA" meaning Not Applicable. In the case of divorce, the counselor will need the divorce decree detailing who has legal custody of the child and can consent to the child's treatment.

Date:______________________

Therapist: _____________________

Patient Information: (Child)

Name:____

Date of Birth:________________________ Age:____

Address:____

City/State:__________________________ Zip:_______

Email:__________________________

Cell Phone: __________________________

Other Numbers:______________________

Who is responsible for payment:_________________________________

How did you hear about our counseling services?_____________________

Please briefly describe the reason for the child's visit today:

____

____

Social Information:

Parents/Guardians (including stepparents):____

Marital Status: ○ never married ○ married ○ separated ○ divorced ○ other______

Previous Marriages: Mother: _____time(s) Date(s):

Father: _____time(s) Date(s):

Name, Age and Sex of Other Children:

(Mother):____

(Father):____

The child presently lives with:________________________

How would you describe his/her current living situation?

____

If the child's parents are separated or divorced describe the visitation arrangements:

____

Who can give permission to seek treatment for the child?

Highest Education Completed:
Mother:__________________ Father:__________________
Employer (Mother): ______________ Position:________________ Length:____
Employer (Father):________________Position:________________ Length:____

Where does the child attend school? ________________________Current Grade _____

Has the child had any academic or behavioral problems in school? ○ Yes ○ No If yes, check all that apply: ○ poor attention span ○ fidgeting ○ not completing/turning in assignments ○ declining/failing grades ○ arguing with adults ○ refusing to follow directions ○ fighting/hitting other students ○ visits to detention/principal ○ learning disabilities ○ other (describe):

Are behavioral problems present in situations other than school (Home/Other places)?
○ Yes ○ No If yes, describe
○ arguing ○ impulsivity ○ refusing to follow directions ○ frequent conflicts with siblings
○ fighting/hitting ○ refusing to do chores ○ isolating in his/her room
○ decreased/increased eating ○ decreased/increased sleep ○ bed wetting ○ fire setting ○ harmful to animals ○ other (describe):

Medical Information:
Does the child have any medical problems? ○ Yes ○ No
Describe:____
Treating Physicians:______________
Specialties: (Pediatrician, etc.): ____________
Date of Last Physical Exam/Consultation:________
List any medication, dosage, and reason (including vitamins, herbs, or over the counter medication) ___________________________________

Were there any problems with the pregnancy or delivery? ○ Yes ○ No If yes, please describe:

Were there any delays in the child's development? ○ Yes ○ No If yes, please describe

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Has the child received counseling previously? ○ Yes ○ No

When, where and reason:

Is any family member currently under the care of a mental health professional (i.e. psychiatrist, psychologist, counselor, etc…)? o Yes o No. If so, for
o individual o marital o group

Does the child or any family members have any history of depression or other similar Problems? o Yes o No
If yes, explain:____
Do you or your family have any history of drug or alcohol problems? o Yes o No
If yes, explain:

Is there a history of abuse (sexual, physical, etc.) towards the child? o Yes o No
If yes,describe:

If yes, has this information been reported to the proper authorities? o Yes o No o N/A
Please feel free to add any additional information:

Name of client: DOB:

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON SECURE MEANS

I, AUTHORIZE: MARTIN COUNSELING, PLLC - 472 PARK GROVE DR. Katy, TX 77450 TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY/MY CHILD'S HEALTH RECORDS AND HEALTH CARE TREATMENT:

O Information related to the scheduling of meetings or other appointments
O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
O My health record, in part or in whole, or summaries of material from my health record
O Other information. Describe: ____

BY THE FOLLOWING NON SECURE MEDIA:
O Unsecured email.
O SMS text message (i.e. traditional text messaging) or other type of "text message."
O Other media.
Describe:____.

TERMINATION
O This authorization will terminate _____ days after the date listed below. OR
O This authorization will terminate when the following event occurs:

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my/my child's protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Signature of client, parent, guardian Date

Credit Card Authorization Form

I authorize Martin Counseling, PLLC to charge this credit card for services rendered, in the case of a missed appointment, or an appointment not canceled within 24 hours of a scheduled session. I understand it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Client Signature Date

Name as it appears on Card: ____

Credit Card #:___________________________________ CCV: __________

Expiration Date: ____________________

Billing Zip Code: __________________________________

Thank you for completing the intake form.