PARENT / GUARDIAN INTAKE FORMS

INFORMED CONSENT – PARENT / GUARDIAN

Consent:
Your signatures below indicate that you consent to entering therapy through an informed decision. The Gerald & Audrey Olson Marriage & Family Therapy Clinic is a teaching clinic and therapy will be conducted by students under the supervision of Licensed Marriage and Family Therapists. In order to provide the best services possible, sessions are subject to video recording or observation by clinic supervisors or other students in the Olson Clinic.

All student therapist and faculty supervisors are required to uphold the *Code of Ethics of the American Association of Marriage and Family Therapists* and Iowa Law. Copies of these codes are available upon request.

All student therapists and faculty supervisors are required to hold information about sessions and clients in confidence. **The clinic will not disclose client information without the expressed written consent of every member involved in treatment. This means that if more than one person is involved in treatment all individuals associated with that treatment must sign a release of information before any information will be provided for use outside the clinic.** The exceptions to this policy are the following circumstances:

_____ Initial
6) There is clear and imminent danger to you or others in which case the clinic may be required to inform the responsible authorities or warn the identified victim. In the event that this occurs, the therapist will inform you of their responsibilities and actions.

_____ Initial
7) In situations of suspected physical, emotional, or sexual abuse of a child, elderly or dependent adult abuse, therapists are required to submit a report to the Department of Human Services and may be required to contact authorities. Again, in this situation you would be informed of the therapist's responsibilities and actions.

_____ Initial
8) The clinic maintains records of treatment, diagnosis, assessment, and treatment planning in order to collaborate with clinic staff and supervisors, and to better inform your treatment and assess the effectiveness of treatment provided. You may request restrictions as to how your case information may be used or shared among clinic staff, but Gerald & Audrey Olson Marriage & Family Therapy Clinic is not required to agree to those restrictions.

_____ Initial
9) Since Gerald & Audrey Olson Marriage & Family Therapy Clinic is training facility, you agree that staff, clinical supervisors and other therapists may have access to confidential information for the purpose of clinical effectiveness. Therapy sessions are videotaped for review, and in signing this informed consent I am agreeing to allow The Gerald & Audrey Olson Marriage & Family Therapy Clinic to videotape my sessions. I understand that videotapes of sessions will be deleted at the termination of a student therapist's training in the program.

_____ Initial
10) If the release of information is mandated by law. Some litigation may require the release of records even without the client's authorization. Student therapist will not typically testify in court (unless mandated) as this is outside of their scope of training and they are not qualified to do so.

I agree that consent to services remains in effect as long as I attend the Gerald & Audrey Olson Marriage & Family Therapy Clinic and can only be revoked by me in writing with such notice being provided to the clinic. Any concerns, questions or grievances may be reported to my therapist or the Clinical Director at (319-368-6493).

I agree to enter the therapy process aware that there may be potential for emotional strains, stresses and life changes as a result of therapy. I agree that The Gerald & Audrey Olson Marriage & Family Therapy Clinic does not guarantee any particular results or outcome from the therapy process.

When I do decide to terminate therapy, I agree to discuss this decision in a regular session with my therapist. Due to the nature of this clinic, if a file goes 60 days with no activity, it will be closed. In the event that I wish to attend therapy again in the future, the file may be reopened by calling 319-368-6493.
_____ (initial)

Fees:
Fees for service will be _____ per session, unless other arrangements have been made with the therapist prior to service. These fees are determined on a sliding fee scale and are due at the time of the session.

Sliding Fee Schedule – Based on 2018 Federal Poverty Guidelines					
Family Size	Minimum	25% Pay	50% Pay	75% Pay	100% Pay
Poverty Level	100%	133%	166%	200%	233%+
1	12,140	16,147	20,152	24,280	28,286+
2	16,460	21,892	27,324	32,920	38,352+
3	20,780	27,637	34,495	41,560	48,417+
4	25,100	33,383	41,666	50,200	58,483+
5	29,420	39,129	48,837	58,840	68,649+
6	33,740	44,874	56,008	67,482	78,614+
7	38,060	50,620	63,180	76,120	88,680+
8	42,380	56,365	70,351	84,760	98,745+
Fee	$10.00	$15.00	$20.00	$25.00	$30.00

Cancellations:
24-hour notice is required for all cancellations. If appropriate notice is not given 50% of the client's fee will be charged.

_____ (initial)

HIPAA:
I acknowledge I have received, have read (or had read to me), and understand the contents of the Gerald & Audrey Olson Marriage & Family Therapy Clinic's Notice of Private Practices. I fully understand its contents and if I had any questions regarding this document it has been fully answered.

_____ (initial)

By signing this form, I certify that I have asked for clarification from my therapist for any aspect of this consent form that does not seem clear. I am also certifying that I am qualified to sign on behalf of myself and have the legal authority to sign to consent to the treatment of any minors.

☐ I have read this form and I AGREE to receive counseling services.

☐ I have read this form and I DECLINE to receive counseling services.

_____
Date

Print Client Name/Legally Authorized Person	Signature	Relationship to Client
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
Student Therapist Name	Signature	Relationship to Client

RELEASE OF INFORMATION – PARENT / GUARDIAN

I, _____, hereby authorize the Gerald and Audrey Olson Marriage and Family Therapy Clinic (hereinafter referred to as the Olson MFT Clinic) to release verbal and/or written information to:

Full name of person or entity	Phone	Fax

Address

For the following purposes:

▫ Treatment and assessment ▫ Coordination of care ▫ Referral of new or additional services

▫Other_____

Specific information to be released includes:

▫ Assessment and diagnosis ▫ Treatment goals ▫ Session Content ▫ Discharge

▫ Other: _____

I understand that by signing this General Authorization I am authorizing the Olson MFT Clinic to disclose my health information to the persons and entities listed above and that any health information or other confidential information in the possession of the persons and entities listed above may be disclosed to the Olson MFT Clinic.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Olson MFT Clinic. I understand that my revocation of this General Authorization will not affect a disclosure that the Olson MFT Clinic has already made under this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Olson MFT Clinic's confidentiality rules. I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

I understand that signing this is not a condition of receiving services.

This authorization will expire 12 months from the date it was signed or on the specified date of ____/____/_____.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)

_____Mental Health _____Substance Abuse _____HIV/AIDS _____ Genetic information including genetic test results

Printed name Client and/or Client's Parent or Legal Guardian	Signature
Printed name Client and/or Client's Parent or Legal Guardian	Signature
Printed name Client and/or Client's Parent or Legal Guardian	Signature

DEMOGRAPHIC FORM - PARENT / GUARDIAN

Name: _____

Name of child: _____

My relationship to the child is: _____

Who has legal custody of the child? _____

My child identifies their gender as: _____

I identify my race and/or ethnicity as: _____

My child's religious affiliation is (if any):_____

What is your child's highest level of education obtained? _____

Number of individuals in my household is:_____.

My household income is: _____

On average, I work about _____ hours per week.

My child's relationship status is:
□ Single
□ In a relationship

What is your relationship status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Cohabitating/Live with
- ☐ Other _____

How did you hear about the Olson Clinic?

_____

The Olson Marriage & Family Therapy Clinic

Current Symptom Checklist

MY CHILD IS FEELING…	Never	Rarely	Sometimes	Frequently	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement of Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about the future					
Excessive feelings of guilt					
Low self-esteem					

MY CHILD IS EXPERIENCING…	Never	Rarely	Sometimes	Frequently	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about a traumatic experience					

I NOTICE MY CHILD…	Never	Rarely	Sometimes	Frequently	For how long?
Is Angry, Irritable, Hostile					
Is euphoric, energized and highly optimistic					
Has racing thoughts					
Is needing less sleep than usual					
Is more talkative					
Mood fluctuates: go up and down					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Risk-taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

MY CHILD'S EATING INVOLVES…	Never	Rarely	Sometimes	Frequently	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss					
A lot of weight gain					

MY CHILD HAS…	Never	Rarely	Sometimes	Frequently	For how long?
Concern about my sexual function					
Discomfort engaging in my sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF CARE	Never	Rarely	Sometimes	Frequently	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

Psychiatric History

Prior outpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior inpatient psychotherapy? YES NO

Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?

Prior and/or current medication use? YES NO

Medication	Dosage	Frequency	Start Date	End Date	Physician

Has any family member had mental or emotional problems that warrant treatment? YES NO
If yes, who / what / why (list all):

_____

_____

_____

List family members

Name	Age	Gender	Relationship to Client

Describe any past or current significant issues in intimate relationships or immediate family relationships:

_____

_____

_____

Medical History

Describe current physical health ☐ Good ☐ Fair ☐ Poor

Comments:

_____

_____

_____

List any non-psychiatric medications and supplements currently being taken (give dosage and reason ☐ Not applicable

_____

_____

_____

List any known allergies ☐ Not applicable

_____

_____

_____

Socio-Economic Status History

Financial Situation of the Family
- ☐ No current financial problems
- ☐ Large indebtedness
- ☐ Poverty or below poverty income
- ☐ Impulsive spending
- ☐ Relationship conflicts over finances

Living Situation of the Child
- ☐ Housing adequate
- ☐ Homeless
- ☐ Housing overcrowded
- ☐ Housing dangerous/deteriorating
- ☐ Living companions dysfunctional