David Cummins Ph.D., Licensed Psychologist

(208) 949-6765 1310 W. Hays St., Boise, ID 83702 DavidCummins.net

(Please Print)

Adolescent's Information to be completed by parent:

______________________ ______________________ ______________________
Child's Last Name Child's First Name Child's Birth date

____ ______________________ ______________________
Street Address City Zip Code

____ ____
Parent's Names Parental Custody

____ ____
Parent's Email Parent's Phone numbers

Please place a check next to areas your child needs assistance with.

- ☐ Depression
- ☐ Stress
- ☐ Anxiety
- ☐ Drug/Alcohol
- ☐ Career
- ☐ Lack of Meaning
- ☐ Health (Sleep, Physical Problems)
- ☐ Eating Issues
- ☐ Body Image
- ☐ Relationships
- ☐ Family Issues
- ☐ Hallucination or Delusions
- ☐ Unwanted Sexual Experiences
- ☐ Traumatic Experiences
- ☐ Thoughts of Harming Myself
- ☐ Thoughts of Harming Others
- ☐ Other: ______________________
- ☐ Other: ______________________

Please describe the concerns for which you are seeking help, including how long you have had these concerns:

____

____

____

____

____

____

Has your child been having suicidal thoughts? ______ Yes ______ No

Has your child ever attempted suicide before? ______ Yes ______ No

Who referred you?____

If your child has seen a therapist or psychiatrist in the past, please indicate when, with whom, and for what? How successful was it?

____

____

Does your child have a history of or are you currently experiencing any medical problems, please list below along with any medication, including herbal/vitamin supplements your child is taking:

Primary Physician:____

Psychiatrist:____

Who does your child live with and what are the relationships and living conditions like?

What is your child's history with alcohol and drugs? What role does it currently play in his/her life?

Give details of family members with mental health and substance issue.

What are your childs strengths? And, how have he/she coped effectively with his/her problems?

How does your child feel about coming to therapy? What would you like him/her to gain from the experience?

Child's Signature ____________________ Date ____________

Parent/Guardian Signature ____________________ Date ____________

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Adolescent Information Form to be completed by adolescent:

It is important that I be as effective in my work with you as I can. Getting to know more about you and your family is an important part of effectively helping you live a happier and healthier life. Please complete this as completely, honestly, and accurately as possible.

(Please Print)

Name ____________________ Email Address ____________________

Cell Phone ____________________

Listed below are a number of possible areas of concern you may have for your child. Please place a check next to areas you wish us to discuss.

- ☐ Depression
- ☐ Stress
- ☐ Anxiety
- ☐ Drug/Alcohol
- ☐ Career
- ☐ Lack of Meaning
- ☐ Health (Sleep, Physical Problems)
- ☐ Eating Issues
- ☐ Body Image
- ☐ Relationships
- ☐ Family Issues
- ☐ Hallucination or Delusions
- ☐ Unwanted Sexual Experiences
- ☐ Traumatic Experiences
- ☐ Thoughts of Harming Myself
- ☐ Thoughts of Harming Others
- ☐ Other: ____________
- ☐ Other: ____________

Please describe why your parents and/or you believe that you need therapy:

How do you feel about going to therapy and what would you like from the time we spend together?

(Please feel free to use backside if needed)

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Agreement for Treatment by Parents/Legal Guardians

Therapy can be a very important resource for children and adolescents. It is common for children and adolescents to be scared, confused, and/or resistant to therapy. It is important that we do whatever we can to help your child/adolescent feel safe, empowered, and optimistic about this process. When appropriate, I encourage you to speak openly about the experience of therapy, to let them know that you are encouraging them to do it out of love and concern, and to allow them to be active in as many of the choices as possible.

As parents, I imagine that you have been under a significant amount of stress yourself. I encourage you to use the resources in your life to help you cope as well as to consider counseling yourself. It is quite common for the child or adolescent to only be part of the problem and solutions of the situation. Growth, healing, and positive change are enhanced when the child/adolescent as well as other family members work collaboratively. I would be happy to make a referral for you if you would like to consider participating in individual or couple's therapy yourself.

I primarily work with the child/adolescent, but want the family to be active in the process and will invite family members to participate in therapy sessions on occasion. It is important to me that we do whatever we can for your child's welfare. Please feel free to let me know if you have any concerns or if you feel the need to actively participate in our therapy sessions. During these discussions, I will retain your child's confidentiality (please see the Parent/Child Confidentiality Agreement).

If the potential of a custody dispute or a court custody hearing exists then I will need to know about it. If you have concerns about your child's welfare in regards to the other guardian, I encourage you to get a professional evaluation and assessment independent of me. My professional ethics prevent me from doing custody evaluations or testifying for one parent against another when doing therapy with your child.

I have read and agree to the above and give my permission for David Cummins to conduct therapy with my child. (**All legal guardians need to sign this agreement for treatment – if you have sole custody, then a copy of court documentation of custodial guardianship need to be included**)

Parent/Legal Guardian (Signature) Date

Parent/Legal Guardian (Printed Name)

Parent/Legal Guardian (Signature) Date

Parent/Legal Guardian (Printed Name)

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Child/Parent Agreement to Confidentiality

I will treat what you tell me with great care and privacy. Generally, the laws of this state prevent me from sharing what you tell me in therapy without your permission. I promise that I will keep everything you say to me private except things that make me concerned about your or other's safety, sharing with your parents how therapy is going, or have to break confidentiality by law. We need to discuss these exceptions, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important, so please read this page carefully and ask me any questions you have.

Exceptions to Confidentiality:

1. **When you or other persons are in physical danger.**

2. **When child abuse or neglect has or is taking place. This includes physical, emotional, and sexual abuse.**

3. **Specific details about therapy will generally be kept private from your parent's or legal guardians. However, Parent's and Legal Guardians have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.**

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

Your Signature Date

Your Printed Name

Parent/Legal Guardian (Signature) Date

Parent/Legal Guardian (Printed Name)

Parent/Legal Guardian (Signature) Date

Parent/Legal Guardian (Printed Name)

David Cummins, Ph. D. Date

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What You Should Know about Therapy and Confidentiality

In therapy, I will treat you and what you tell me with great care. My main role in working with you is to help you to live a happier and healthier life. This takes place in different ways due to the complexity of people's presenting issues, their histories, and how they work best within their world. I am committed to gaining the best understanding possible of your particular situation, create an environment of trust and security, and work to help you identify the most effective means of achieving your goals in therapy. I believe that most every one of my clients who has worked diligently in and out of therapy has made substantial gains in the areas of life that they wish to improve.

I strive to make myself available to my clients in times of crisis and emergency. However, **there are times when I am not available** due to being out of town, working in other capacities, etc. If any emergencies take place and you are unable to contact me, please leave a message on my phone and use your resources (families, friends, etc.), call 911, and/or go to the nearest hospital emergency room. I will try to respond to you as soon as possible.

Confidentiality plays a very important role in therapy. With the exception of certain specific exceptions described below, you have the right to confidentiality. You may direct me to share information with whomever you chose, and you may revoke permission at any time. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission to do so. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will *never* be revealed to someone else. **There are some circumstances when the law requires me to disclose information you may share with me to others.** You need to be aware of these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. These are very important issues, so please read the following carefully and keep a copy for yourself. At our next meeting, we can discuss any questions you might have.

1. **When you or other identifiable persons are in physical danger (including suicidality and homicidality) or you are unable to reasonably take care of yourself,** the law requires me to tell others about it to ensure your and other peoples' safety.

2. **Disclosure of information that indicates that child (or elderly) abuse and/or neglect has occurred by an identifiable person or situation that has not been previously reported or investigated.**

3. **I may sometimes consult (talk) with another professional to ensure that I am giving you the best treatment possible**. I promise to keep your identity as anonymous as possible if I consult about your case. This other person is also required by professional ethics to keep your information confidential.

4. **In regard to North End Wellness, insurance, billing, and money matters:**
   A. I am employed with North End Wellness, LLC and do all billing and work practices through them. All North End Wellness, LLC employees are HIPAA compliant in protocol. These employees are only privy to information needed for billing and insurance and do not have any access to clinical information.
   B. Some insurance companies may require diagnoses and other treatment information about your therapy for billing purposes.
   C. If problems arise with your billing and/or payment a North End Wellness, LLC billing agent may contact you through email, mail, or by phone to help in resolving the matter.

D. If payment is not made in a reasonable amount of time, I have the right to report the billing for collection purposes.

5. **Record keeping:** All records are stored in a designated area and under lock and key at all times.
6. **Electronic Submissions**: You are also protected under the provisions of the Federal Health Insurance HIPPA Act. This law ensures the confidentially of all electronic transmissions of information about you. When I transmit information about you electronically (sending bills or faxing information) it is done with safeguards in place to insure confidentiality

If any of the above situations occur that would warrant me having to share information with others, I would take reasonable attempts to empower you as much as possible so that you can make the best decision for your loved ones and yourself. I promise to reveal only the information that is needed to protect you, other persons, or for billing requirements.

The signatures here confirms that you have read, understand, and agree to abide by the points presented above.

_____________________________ _____________________________________ ____________

Printed Name Signature of client (or person acting for client) Date

Fees and Services*

Payment will be paid in full at time of service.

Please check one of the following:

☐ I agree to pay $200 for each hour of service.

☐ I understand I am responsible for paying all fees in cash, Venmo, check or HSA.

☐ I understand that I cannot use credit or debit card as form of payment.

Cancellations/Missed Appointments

If an appointment is missed or canceled with less than one business days' notice, you will be directly billed $100. Emergencies and illnesses occasionally happen to cause missed sessions. If this is the case please let us know as soon as possible so this fee can be waived and so that accommodations can be made.

Insurance and Billing

I am "fee for service" and expect full payment at time of service. However, if you have insurance, you may be able to receive some reimbursement for your counseling sessions. I am more than happy to have my billing manager submit your claims to your insurance company as an out-of-network therapy provider to help reduce your costs. If you would like this service, please complete the insurance information portion of the intake forms and my billing manager will submit all of your sessions to your insurance company for you. Your insurance company will mail you a check for any portion of our counseling sessions that are covered by your plan. As far as payment goes, I only accept payment at time of service in the form of cash, check, or HSA cards at time of service. If you would like to have our sessions submitted to insurance as an out of net-work service. Please send the following information to my billing agent, Christine Aros, emeraldstar@gmail.com

1. Copy of the front and back of your insurance card.
2. Your date of birth
3. Your gender
4. If you are not the policy holder, please send the name and address of the person you are insured under.

I have read the above and agree to the terms set forth for fees, missed appointments, and late cancellations.

____

Parent's or Guardian's Signature Today's Date