PEMBERTON & YOUNG COUNSELING

Damon Pemberton, LCSW • Krista Pemberton, LCSW • Maureen Young, LCSW

Pemberton & Young Counseling, LLC • 1345 W 9th Ave, Suite 201 • Anchorage, Alaska 99501
Phone: 907.258.8003 Fax: 907.258.8004 • info@pemyoung.com • www.pembertonandyoung.com

PATIENT REGISTRATION

PATIENT INFORMATION

Last name: _____ First Name: _____ M.I.: _____
DOB: _____ SSN: _____ Gender: M / F / O
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which Number is best to contact you? ☐ Home ☐ Work ☐ Cell

Email Address: _____

☐ I authorize the use of this email address for scheduling and billing purposes

Emergency Contact Name & Phone: _____Relation to patient: _____

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is responsible for costs not covered by insurance?
Last Name: _____ First Name: _____ M.I.: _____
Relation to Patient: _____ *Photo ID and Proof of Guardianship Required*
Marital Status: M / S / D SSN: _____ DOB: _____ Gender: M / F / O
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer's Name & Phone: _____

PRIMARY INSURANCE - *ALL INFORMATION MUST BE PROVIDED*

Insurance Name: _____ Provider Phone Number: _____
Claims Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O
DOB: _____ SSN: _____Employer Name & Phone: _____

SECONDARY INSURANCE: ☐ Y ☐ N

Insurance Name: _____ Provider Phone Number: _____
Claims Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relation to Patient: _____ Gender: M / F / O
DOB: _____ SSN: _____Employer Name & Phone: _____

TERTIARY INSURANCE: ☐ Y ☐ N

I hereby declare the information provided herein is true and correct to the best of my knowledge.

Name of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

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CONSENT FOR TREATMENT OF A MINOR

We (Parent names), _____and _____ are legal custodial parents with decision-making responsibility for (Minor's Name) _____ _____, a minor. If sole legal custodian, please attach a copy of Permanent Court Order Provision.

We hereby consent to our Pemberton & Young Counseling, LLC Provider in their capacity as a Licensed Clinical Social Worker to begin mental health assessment and treatment of said minor on (Date) _____.

Authorization will be in effect until such time that this psychotherapeutic relationship is terminated. As legal custodial parents, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

I understand I have the following rights with respect to my child's psychotherapy treatment:

- I have the right to withdraw or withhold consent for treatment at anytime.
- I understand that there are potential risks and benefits associated with any type of psychotherapy, and that despite my efforts and the efforts of my child's Provider, his/her condition may not improve. I understand that benefit from psychotherapy cannot be guaranteed or assured.
- I understand that I have the right to access my child's medical information and copies of medical records in accordance with Alaska law.

Both parents must consent for treatment unless the treatment is court ordered or one parents is sole legal custodian (please attach provision).

I have read and understand the information provided above and have had the opportunity to discuss questions with my child's Provider.

Signature of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____

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LIMITS OF CONFIDENTIALITY FOR PSYCHOTHERAPY

Any information discussed during therapy sessions, is confidential, and will not be shared without written permission, except under the following conditions:

- The client threatens suicide.
- The client threatens harm to another person(s), including murder, assault, or other harm.
- The client reports suspected child abuse, including but not limited to: physical beatings, sexual abuse and neglect.
- The client reports abuse of the elderly.

State law mandates that mental health professionals are required to report these situations to the appropriate persons or agencies.

In addition, if the client is involved in a legal action and claims mental health issues related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), mental health records may be required to be released.

Communications between clinicians at PEMBERTON AND YOUNG COUNSELING, LLC and the client will otherwise be deemed confidential as stated under Alaska State Law.

Having read and understood the above, I agree to the limits of confidentiality.

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

Signature of Minor (if applicable): _____ Date: _____

Pemberton & Young Counseling, LLC

Provider Signature: _____ Date: _____

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CLINIC POLICIES

Thank you for choosing Pemberton & Young Counseling, LLC as your behavioral health provider, we look forward to working with you. The purpose of this form is to provide you with important information regarding our policies and your financial responsibility for payment of services.

FINANCIAL: As a courtesy, we will bill your insurance if you provide **valid proof of coverage** at the time of service. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claim is your responsibility. **You are expected to pay any/all deductibles and co-pays at the time of service and are responsible for paying any balance that is not covered by your insurance.** Any date of service balance remaining after resolution of your insurance claim will be due (30) days after receipt of billing statement. We accept cash, check, and major credit cards. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent to receive this information electronically. If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be subject to referral to a collection agency.

Responsible Party Initials ____

CHILDREN: A parent or legal guardian must accompany all children under the age of 18 years to the initial intake session and sign all required consents prior to initiating services. I understand that any child under the age of 18 that arrives at the initial appointment without completed parental consents will be rescheduled. I understand that in the case of a child who has legal guardians living in separate households; only one parent/guardian signature is required for treatment. However, your provider will make every reasonable attempt to contact and receive consent and engagement from both legal guardians. I understand that I may be required to provide proof of legal guardianship status.

If your minor child will be attending regular group or individual sessions unaccompanied by a parent, Pemberton & Young Counseling, LLC will require a signed card on file authorization for any copays or coinsurance due at the time of service. Coinsurance or copays for on file credit card authorizations may be processed the following day.

Responsible Party Initials ____

MISSED APPOINTMENTS: I understand that therapy appointments cancelled with less than 24 hours notice will result in a late cancel/ no show fee of $25.00 for the first occurrence. Any subsequent late cancel/no show for appointments will be charged 50% of the appointment cost. Late cancel/ no show charges are not covered by insurance payments and are the responsibility of the patient. Missed appointment fees will be applied to all service types including group, individual and family sessions.

Responsible Party Initials ____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance, I understand that my insurance company will have access to necessary behavioral health records from services provided by Pemberton & Young Counseling, LLC. I authorize the exchange of information necessary for payment of services between Pemberton & Young Counseling, LLC and my insurance company. I authorize payment directly to Pemberton & Young Counseling, LLC for services rendered. I also understand that I am responsible for any amount not covered or that is deemed over usual and customary fees by my insurance carrier or agency unless otherwise outlined by in-network insurance agreements.

Responsible Party Initials ____

SELF-PAYING PATIENTS: I understand that I am responsible for my bill and that the total charge is due at the time of service.

Responsible Party Initials ____

TELEHEALTH: "Telehealth" or "Telemedicine" is a service provided for clients physically present in the State of Alaska. State licensure requirements mandate that sessions cannot take place if the client is located in a state in which their provider is not licensed. I understand that telehealth includes the practice of assessment, diagnosis, consultation, treatment, transfer of protected health information, and psychoeducation using interactive audio, video, and data communications. Should telehealth be an option for my therapy I understand that I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be.

Responsible Party Initials ____

Pemberton & Young Counseling, LLC's clinic policies have been reviewed, understood, and agreed to by:

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY
We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. PEMBERTON AND YOUNG COUNSELING, LLC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.
Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, you may give us additional written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, *but only if you agree that we may do so.*

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials: health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, emails, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format.

Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge receipt of PEMBERTON AND YOUNG COUNSELING, LLC Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

Name of Patient [print]: _____

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____

PSYCHOTHERAPY PAPERWORK

CHILD & ADOLESCENT HISTORY FORM

_____

Name of Patient

_____ ___/___/_____

Person Completing Date

It is very important to gather an individual's history to formulate a complete understanding of symptoms, identify a specific diagnosis and develop a meaningful treatment plan. Although this form is lengthy, taking your time to respond to the questions with complete and accurate responses will greatly help in understanding the symptoms your child may be experiencing.

You may wish to ask others including your child, spouse, family, or friends for information to help your memory. Should certain questions not pertain to your child, please mark with N/A. In some cases, you may not have enough information to answer a particular question. If so, please indicate this on the form.

Please return this completed form to our office as soon as possible.

CHILD/FAMILY HISTORY QUESTIONNAIRE

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN FULL

DEMOGRAPHIC INFORMATION

Form completed by: _____ Relationship to child: _____

Child's name: _____ Date of Birth: _____ Age: _____

Gender: M / F / O Race/Ethnicity: _____ Primary Language: _____

Current School: _____ Current Grade: _____

Who referred you to our office? _____

Who is your Pediatrician/Primary Care Provider? _____

What are your primary concerns regarding your child? _____

_____

FAMILY INFORMATION

Parents names and (age): **Occupation:**

Mother: _____ (____) _____

Father: _____ (____) _____

Guardian: _____ (____) _____

Are biological parent's divorced? Yes / No **Child's age at divorce:** _____

Who has custody: _____ Describe Visitation Schedule: _____

_____

If parent(s) have remarried:

Step-Father's Name: _____ Step-Mother's Name: _____

Contact/Relationship with biological mother: _____

Contact/Relationship with biological father: _____

Number of out of state moves since child's birth? ____ History of OCS involvement? Yes / No

Is your child adopted? Yes / No **Age at adoption:** _____

Child's Religion: _____ How often does child attend service? _____

Other children in family?

Name	Age	Gender	Grade	Relationship

Any additional household members? _____

_____

HEALTH HISTORY

Developmental Milestones (months):

_____ Sat up _____ Walked _____ First words (3 words or more)

_____ Crawled _____ Bowel trained _____ Bladder trained (day)

_____ Bladder trained (night)

Does your child have ongoing bladder or bowel accidents: Yes / No

Was there anything in the first three years of your child's life that you thought might affect growth, development, or school success? _____

_____

Previous Illnesses (Circle all that apply):

High fevers	Allergies	Ear Tubes	Recurrent ear infections
Poor Growth	Surgeries	Meningitis	Seizures or staring spells
Breathing problems	Hearing or vision problems		

Please Describe: _____

_____

Any overnight medical hospitalizations? Yes / No If yes, please describe: _____

_____

Behavior Problems during early childhood *(Circle all that apply):*

Hyperactive	Stiff when held	Difficult to calm	Aggressive
Severe separation anxiety	Solitary play	Overly sensitive to sound/touch	
Extreme tantrums	Unusual motor behaviors		

Has your child ever had a serious hit to the head, concussion or other brain injury? Y / N

How many times? _____ At what age(s)? _____

Did your child ever have a loss of consciousness (been knocked out)? Yes / No

How many times? _____ At what age(s)? _____

Additional information: _____

_____

CURRENT MEDICAL INFORMATION

Height: _____ Weight: _____ Past or current medical problems: _____

_____

Does your child require glasses or contact lenses? Yes / No

Is their vision fully corrected with glasses/contact lenses? Yes / No

Does your child have a hearing impairment? Yes / No Hearing aid? Yes / No

Does your child have difficulty falling asleep? Yes / No Staying asleep? Yes / No

Typical bedtime: _____

Typically awake at: _____

Hours of sleep per night? _____

History of sleep study? *Yes / No*

Tonsils and/or adenoids removed? Yes / No Sleep better after? Yes / No

---

Does your child have problems with eating or appetite? Circle all that apply:

Recent weight gain/loss Binge eating Unaware of hunger or being full

Picky eater Hiding/hoarding food Appetite changes

Chronically hungry Foods rejected based on texture and/or appearance

Has your child had treatment for a psychological problem? Yes / No

When? _____ Type of treatment *(circle all that apply)*

Individual therapy family therapy group therapy hospitalization residential care

What for? _____

Does your child take medications for behavioral/emotional problems? Yes / No

At what age did your child begin taking medications? _____ Prescribing Doctor_____

What medications has your child taken in the past? _____

Current Medications: _____

_____

_____

Is your child receiving therapy (individual, family or group) now? Yes / No

If Yes, with whom? _____

Has your child ever hurt themselves on purpose? Yes / No How? _____

Has your child ever threatened to hurt themselves? Yes / No

SUBSTANCE USE/ABUSE HISTORY

Has your child ever tried/used *(Circle all that apply)*:

Meth	Cocaine/crack	Gas/inhalants	Pain pills/sedatives	Marijuana
Nicotine	LSD/Hallucinogens	Spice	Ecstasy	Alcohol

Other: _____

FAMILY HISTORY

(family defined as siblings, parents, grandparents aunts/uncles and first cousins)

Condition	**Relation**
Learning Disabilities	
Depression/Bipolar Disorder	
Alcoholism/Drug Addiction	
Epilepsy	
Autism Spectrum Disorders	
Hyperactivity	
Anxiety	
Speech Delay	
Tic or nervous behaviors	
Psychiatric Hospitalization	
Other	

SCHOOL HISTORY

Current School: _____ **Grade:** _____ **Teacher:** _____

Previous schools attended (include preschool and grades)

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Does your child have a current IEP or 504? Yes / No

Classification?

□ Specific learning disability (SLD) □ Speech/language disorder

□ Emotionally disturbed (ED or SED) □ Other health impaired (OHI)

□ Educational Autism □ Early Childhood developmental delay (ECDD)

□ Intellectual disability □ Traumatic Brain Injury

What services and/or accommodations does your child receive?_____

_____

Has your child ever repeated a grade? Yes / No What grade(s): _____

Was your child ever suspended or expelled? Yes / No How many times? _____

Has your child's teacher(s) reported any of the problems below? (*Circle all that apply)*

Social problems	Attention/concentration	Learning/academic
Hyperactivity	Daydreaming	Aggression
Behavior problems	Not following directions	Poor memory
Distractibility	Poor handwriting	Problems with peer relationships

Time your child spends on homework each day _____ (hours)

Time you spend helping _____ (hours)

Comments about school: _____

_____

Does your child participate in sports or other recreational activities? Yes / No

If so, what are they?_____

Is your family/child involved in any litigation or legal proceedings with the following?

□ Worker's Compensation □ Divorce □ Custody

□ Personal injury □ DFYS/OCS

BEHAVIORAL HISTORY:

Please circle any of the following that concern you about your child:

Disobedience	Whining	Poor self/body awareness
Nightmares	Clumsiness	Immature/atypical play
Memory Problems	Moodiness	Verbal Communication
Difficulty sleeping	Headaches	Comprehension
Low self-esteem	Stomach aches	Judgement/Safety Issues
Frequent crying	Lack of friends	Rigid/ritualized behaviors
Dawdling	Unacceptable friends	Attachment
Disorganization	Stealing	Lack of remorse/empathy
Excessive screen time	Hitting	Arguing
Tantrums	Sexual behavior	Lying
Substance abuse	Sensory processing	Destroy property

Has your child ever: *(Please check all that apply)*

☐ Been physically abused ☐ Been sexually abused

By whom _____ For how long/how many times _____

Circumstances surrounding abuse: _____

_____

_____

_____

_____

Has the above indicated abuse:

☐ Been Reported ☐ Not Been Reported

Results of report:

☐ Substantiated ☐ Not Substantiated

Has your child ever: *(Please check all that apply)*

☐ Been arrested or adjudicated
For what _____ Result _____

☐ Run away from home
When _____ For how long _____

☐ Set a fire
When _____ Where _____

☐ Assaulted someone
Who _____ What Happened _____

☐ Destroyed property
When _____ How _____

☐ Threatened to hurt self
When _____ How _____

☐ Hurt self
When _____ How _____

☐ Threatened to hurt someone else
When _____ Who _____ How _____

☐ Cruelty to animals
When _____ What _____

☐ Used a weapon
When _____ What _____

☐ Has Been Sexually active

☐ Gang Activity

DISCIPLINE

When does your child need to be disciplined? _____

_____

_____

What do you do? _____

_____

_____

How does your child respond? _____

_____

_____

_____

FAMILY ACTIVITIES

What does your child like to do? _____

What do you enjoy doing with your child? _____

What are your child's strengths? _____

What does your family do together? _____

How often does your child read alone? _____

How much screen time does your child have on a typical day? _____

On a typical weekend day? _____

What computer software/Apps do you have for your child? _____

Does your child have a best friend? Yes / No

Does your child play with a consistent group of children in school? Yes / No

In your neighborhood? Yes / No

What problem(s) does your child have in getting along with friends? _____

_____

What problem(s) does your child have in getting along with siblings? _____

What are your child's chores? _____

What problems are there getting them done? _____

ADDITIONAL INFORMATION

Please include any other information that will help us better understand your child.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____