AMANDA J. DUDDLESON, LCSW

address:222 S Frances St. South Bend, IN 46617-3004

(Phone) 574.635.5826 I (Fax) 574-314-6506 I email: amanda@dcounselingllc.com

Identifying Information for client (Child): DATE_____

Name: _____Date of Birth:_____
First Middle Initial Last

Age: ____ Sex: M F gender pronoun preference:_____

Address:_____

Main Phone_____

***Would you like ❑ text OR ❑ email appointment reminders?**

Yes No ↑ **(choose one)**

Email: _____

May we call you at home? Yes No May we leave messages at home? Yes No

Parent/Guardian Information	+DOB of Insured – REQUIRED FOR INS. BILLING
Name	Name
•Address	•Address •if different from above
email	email
phone	phone
Employer/Title	Employer/Title
+DOB of Insured	+DOB of Insured

May we call you at work? Yes No May we leave messages at work? Yes No

Family and important relationship information:

(CHILD) Please list individuals who live with you. (Children, siblings, parents, friends, relatives)

Name	Age	relationship	Name	Age	relationship

•••EMERGENCY CONTACT (other than parents) •••

_____ _____

Name Relationship Phone

School Information

School _____Current grade level_____Teacher _____

How do you do in school? Do you like school?_____

Baby Stuff

How much did you weigh at birth? _____Distress? no Distress? on time? early? late? any complications or problems at birth or near after birth? if yes please describe?

_____

Difficulties as a newborn, toddler?_____

Preschooler difficulties?_____

Developmental milestone concerns or difficulties:_____

Present Situation: Please circle any of the following problems that pertain to child/teen.

Nervousness	Depression/sad a lot	Fears	Motivation
Shyness	Frequent conflict with peers	Suicidal thoughts	Aggressiveness
Separation difficulty	Divorce	Family has financial stress	Sexual or physical abuse
•Drug use	•Alcohol use	School bullying	Family relationships
Anger	Self-control	Unhappiness	Difficulty paying attention
Tension	Stress	Tiredness	Sleep problems
self harm/ cutting	Headaches	Anxiousness	Urge to repeat actions
Too much energy	Panic attacks	Concentration	Mood swings
Loneliness	Feeling inferior	Isolation or withdrawal	Impulsivity
Crying episodes	Academic difficulties	Physical health problems	Troublesome thoughts
hearing things not there	adopted	Delusions	Control issues
Frequent tantrums	Nightmares	Frequent fighting: parents	Bed Wetting/bowel troubles
Relationships w/ parent(s)	Eating problems	Stomach Aches	Recent death or multiple losses/ greif

In your own words, please describe issues you would like to address in therapy:

what do you like to do for fun? ex) hobbies or interests?

Health Information:

Family Physician: _____location_____

Last seen: _____Date of last physical exam: _____

Child on any medications? Yes No If yes, list the type of medication and reason for taking it.

medication/ dosage	reason	who prescribes?

Significant Health problems:(medical trauma? surgeries?) If Yes, please describe briefly.

_____

_____

Previous Treatment? Has child had any previous therapy/counseling? Yes No *If yes, please give Therapist/ Doctor/Agency and when.

_____

Psychiatric Hospitalization? Yes No If yes, where/when:

_____

Has child experienced physical, sexual or other traumatic/disturbing experiences in childhood? (including witnessing domestic violence) Yes No

_____

Client's or Authorized Person's Signature

I acknowledge Amanda J. Duddleson, LCSW Services privacy notice, as required by HIPAA, has been made available to me. One facet of this notice outlines the information which can be released to insurance companies in order to process claims.

♦_____ _____

Parent/Guardian signature Date

I authorize payment of medical benefits to the provider for mental health services delivered:

♦_____ _____

Parent/Guardian signature Date

Permission to Treat: REQUIRED

I give my permission for Amanda J. Duddleson, LCSW (provider) to provide _____ (Your Child's Name) with mental health services that are within the scope of her license, certification and training.

_____ _____

Parent/Guardian signature Date

Amanda J. Duddleson, LCSW – Services Policies Payment Policy and Confidentiality Disclaimer

Initial Individual Evaluation	$150.00	Group Counseling	$ 55.00
Individual Counseling	$130.00	Couples/Family Counseling	$140.00

*other Fee agreement
date_____ $_____ therapist initials_____

*Insurance co-payment is due at the time of each visit

NOTES: Insurance _____Deductible _____Met? Y N Copay$ _____

Ins. Co. phone_____-_____-_____

Payment in full is expected at the conclusion of each session unless other arrangements have been made in advance. If we can verify your insurance benefits at the time of service and your deductible has been met, we will accept the amount (your co-pay) your insurance will not cover and bill them for the remaining amount. This also applies to all HMO's with a specific co-pay. In the event that your insurance company would deny payment at any time, payment for services provided then become your responsibility. Failure to pay for charges may result in the account being sent to Collections. For those whose insurance coverage or financial status does not allow payment in full, alternate payment schedule needs to be discussed with the clinician and a specific payment plan arranged with the office manager.

Initial_____I have read and understand these policies and agree to accept them.

Confidentiality Disclaimer:

Understand that you are financially responsible for any remaining balance on your account once reasonable efforts to collect from your insurance company have been made. However, failure to respond in a reasonable manner to any accumulated debt on your account may result in referral to collections. Should this occur we will follow all HIPAA requirements to protect your confidentiality. Your name, address, account balance, and other identifying information necessary to the collection procedures may be legally released to collect payment of debt. Your signature below indicates that you understand this possibility.

Initial_____I have read and understand these policies and agree to accept them.

Missed Appointments:

A specific time has been reserved exclusively for you when a therapy appointment is made. Therefore, notice is required 24 hours in advance of the scheduled appointment should you find you would be unable to keep your appointment. Appointments canceled with less than 24-hour notice will result in an assessment at a rate of a $30 fee charged for first infraction. Second infraction : $60 and thereafter $120 full session fee. Should you fail to keep a scheduled appointment without advance notice (no show); a fee will be assessed rates outlined above. It should be understood that insurance policies will not cover costs incurred due to missed appointments. Your signature below indicates your understanding of this process.

Initial_____I have read and understand these policies and agree to accept them.

Education, Experience and Supervision:

Your provider, AMANDA J. DUDDLESON, LCSW is a Licensed Clinical Social Worker in the state of Indiana. She holds a Masters in Social Work from Indiana University, with emphasis in Mental Health. She may consult with other mental health professionals within the practice, about how best to serve you, in context of clinical consultation. Names withheld for privacy.

Initial_____I have read and understand these policies and agree to accept them.

Crisis and Emergency Situations

In the event of a crisis or emergency situation, you may call your provider, AMANDA J. DUDDLESON, LCSW. She is generally available TUES , THURS, FRI 830 AM -5PM. In the event you reach her voice mail, please leave a message advising of the situation, but keep in mind she may not be able to return your call quickly. If your situation warrants immediate action, you should immediately call 911 or go to the nearest emergency room or crisis center for help.

Emergency psychiatric inpatient facilities: (Adults/ 13+) Memorial Epworth 574-647-8400

(children below 13 years) Michiana Behavioral Health (plymouth) 800.795.6252 or 574.936.3784

Initial_____I have read and understand these policies and agree to accept them.

Email and Internet Communications

Your provider may utilize current technology to communicate with you, including, but not limited to: email and internet websites. E-mail or texting is for administrative purposes only not for information to be discussed within session. •Please note that in the event of a crisis or emergency, do not use email or internet to communicate with your provider. You should call your provider at the office number listed above. If she is unavailable, dial 911 or go to the nearest crisis center or emergency room.

Your provider includes the following disclaimer on all email to or regarding clients:

"This e-mail is not a secured data transmission for Protected Health Information (PHI) as defined by the Healthcare Portability and Accountability Act (HIPAA), and it is the responsibility of all parties involved to take all reasonable actions to protect this message from non-authorized disclosure. This e-mail is intended for the recipient only. If you receive this e-mail in error, you should notify the sender and destroy the e-mail immediately. Disclosure of the information contained herein could subject to disclosure to civil or criminal penalties under state and federal privacy laws"

Initial_____I have read and understand these policies and agree to accept them.

I have read and understand these above policies and agree to accept them.

♦_____ _____

Parent/Guardian signature Date