Kenny Wolford, MA, LPC, LMFT

Licensed Marriage and Family Therapist #T0637 (Oregon)
Licensed Professional Counselor #C2212 (Oregon)

Child/Adolescent Client Information/Consent Form

Submit by Email

Print Form

This is an electronically fillable form. You can type directly into each field.
Please do your best to answer all questions. This information will be used in your first session as a starting point for discussion. When finished completing the form, you can return to the top right hand corner of this page and click on the "Print" button.. Please bring a printed version with you to your appointment. You will sign and date the form at the beginning of your first appointment.

Parent(s) Legal Name(s): Today's Date:

Child's Legal Name:

Home Address:

City, State, Zipcode:

Home Phone #: Cell Phone #:

Child's Birthdate: Gender: Male Female

Please Enter Complete Email Address:

Does anyone else have access to your e-mail address? Yes No

Parent(s) Living Arrangement:

Alone w/Partner w/Partner & Kids w/Kids w/Family

Names and Ages of Other Children (if Applicable):

If Kids live at home part time or away from home, please describe arrangement:

Please describe what brings your child/adolescent to counseling at this time:

What do you/your child hope to accomplish through counseling?

What have you/your child already done to deal with the difficulties?

Have you or your child had previous psychological counseling or psychiatric help?

◯ **Yes** ◯ **No**

Check all that apply:

☐ **Individual Counseling** ☐ **Couples' Counseling** ☐ **Group Counseling** ☐ **Family Counseling**

If yes, when and where did you/your child receive counseling and what were the issues:

List any medications and dosages your child are currently taking:

Please list any significant health problems that your child has been treated for or are currently being treated for:

What are your Child's biggest strengths? What do they do for fun/to relax?

Does your child exercise? ◯ **Yes** ◯ **No** **How Many Times Per Week:** **For How Long?**

What type of exercise:

Describe your child's eating habits and diet?

Interactions between client and therapist are confidential. Unless I have specific permission from you, I will not discuss the content of our sessions with any outside parties. There are four exceptions to confidentiality that Oregon State law requires mental health professionals to report.

1. Incidences of child or elder abuse.
2. Intent to commit suicide.
3. Threats to do harm to self or another person.
4. Court Order.

Additionally, in the event of a billing dispute, names, dates and lengths will be disclosed to a collection agency and/or attorney.

The community that we live in can often feel small and the possibility that we may see one another outside of therapy is always present. Your confidentiality is first and foremost in such situations and therefore, I leave it up to you if you would like to verbally or non-verbally recognize our encounter. I will follow your lead in such situations as I understand that everyone has a different comfort level when it comes to the privacy of their therapy.

If I am not able to make an appointment, I will cancel the appointment by telephone with at least a 24-hour notice.
If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the full session fee.
Fees are:

$110.00 per 50 minute session for individual child/adolescent, or families.

All Fees are due at the time of service and can be paid by check, cash or credit card (visa, mastercard or Am-ex)
I allow limited contact between sessions for informational purposes or emergencies. Any contact by either phone or email that is longer than 10 minutes will be billed at the rates above in half hour increments.

Insurance companies may or may not cover therapy. Clients are required to pay Active Enhancement, LLC directly and then apply for insurance reimbursement through their provider. If additional information is needed for you to file this claim, I will be happy to supply that information in a timely manner if you provide clear instructions by email.

The door access to my office building is unlocked during regular business hours only. If you find the door locked for your appointment, the code to gain access is 9262*. Please have a seat in the waiting room as I am most often with other clients until your specific time. The screen between the therapy room and waiting room is meant to protect your privacy while waiting, but cannot be guaranteed to do so.

I have read and understand all aspects of this form and agree to the terms and conditions. By signing below, I am consenting to therapy and releasing Active Enhancement, LLC/Kenny Wolford, M.A., M.F.T. from any and all liability resulting from therapy. I am the party responsible for payment of services and will pay in full at time of each therapy session. My signature below also confirms that I have received a copy of the "HIPAA Notice of Privacy Practices" and a "Professional Disclosure Statement" at the beginning of the first therapy session. I also understand that I can view and download copies of both of the above at Kenny's website: www.activeenhancement.com under the 'client forms' tab.

Printed Paren Legal Name(s): _____ **Date:** _____

Signatures _____ Date: _____

Please Return to Page 1 of this Form and Print a copy to bring to your first appointment. You may also click on the "submit by Email" button. Not all email servers support this function, so please be sure to print a hard copy and bring it with you to the appointment.