MAIN LINE THERAPY
CENTER

Jennifer Torresson, LMFT
PA License# MF000903

New Client Packet (Child)

Client's Full Name: _____ Nickname: _____

Parent / Guardian Name: _____ Phone: _____

Address: _____

Email: _____ Today's Date:_____

ISSUES AND CONCERNS

What brings you and your child to therapy? Please describe any emotional, behavioral, social, or family concerns you would like help addressing. Are there particular situations or patterns that have been challenging for your child or family? Please list all behaviors you can think of.

_____
_____
_____
_____
_____

Your Child's Strengths. What are some of your child's strengths, interests, talents, and positive qualities? What makes your child happy, and what do you appreciate most about them?? _____

_____
_____

Other Concerns. Do you have any concerns about your child that you have not mentioned yet? _____

_____
_____

Your Hopes for Therapy. What changes would you most like to see as a result of therapy? How would you know that your child and family are making progress??

_____
_____

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What does your child think about coming to therapy? Have they expressed any concerns, hopes, or feelings about participating???

_____
_____

FAMILY HISTORY

Please identify your child's parents or legal guardians, including adoptive parents or other caregivers where applicable.:

Mother: _____ Father: _____

Who has Legal Guardianship of your child? _____

Are there any custody arrangements, parenting schedules, family transitions, or significant changes in your child's living situation that would be helpful for me to understand? _____
_____

Who else does your child currently live with?

NAMES	AGES	RELATIONSHIP TO CHILD

Who are the important people in your child's life who do not live in your household? This may include grandparents, other relatives, friends, caregivers, or trusted adults.

NAMES	AGES	RELATIONSHIP TO CHILD

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Please describe any past counseling that either your child or any family member has had.
_____
_____
_____

Has there ever been an evaluation, testing or assessment, or has a diagnosis been made or suggested based on concerns about your child?_____
_____
_____

Has your child been affected by alcohol use, substance use, or addiction within the family? If so, please share any information you feel may be helpful.: _____
_____
_____

EDUCATION HISTORY

What school does your child attend? _____ Current Grade:_____

How is your child doing at school academically, socially, and emotionally? Have teachers or school staff shared any particular strengths or concerns??_____
_____
_____

Who knows your child best at school?_____
_____
_____

Has your child ever repeated a grade? If so, which one? _____
_____
_____

Does your child currently receive, or have they previously received, school-based support services, an IEP, a 504 Plan, or other learning or behavioral accommodations? _____
_____
_____

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Has your child experienced any of the following issues at school?

- Fighting
- Difficulty making or maintaining friendships
- Suspension
- Attendance or school avoidance concerns
- Difficulty completing assignments
- Peer pressure or concerning peer relationships
- Drugs/Alcohol
- Detention
- Learning Disabilities
- Behavioral or emotional challenges
- Academic challenges
- Bullying

MEDICAL HISTORY

What is the name of your Child's Physician? _____ Phone:_____

Date of your child's last medical examination: _____

Did your child's mother smoke tobacco, or use any alcohol, drugs or medications during the pregnancy? If so, please provide details: _____
_____
_____

Is there anything about your child's pregnancy, birth, or early development that you believe may be relevant to their emotional or behavioral health? Please share what you know and feel comfortable providing:_____
_____
_____

Has your child experienced any of the following medical problems?

Serious Accident	Hospitalization	Surgery	Asthma
Head Injury	High Fever	Seizures	Eye/Ear Problems
Meningitis	Hearing Problems	Allergies	Loss of Consciousness

Please provide details:_____
_____
_____

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Please describe any current medical conditions, developmental concerns, disabilities, or other health-related needs that may be relevant to your child's care: _____
_____
_____

Please list current medications taken by your child on a regular basis: _____
_____
_____

OTHER HISTORY

Has your child experienced any traumatic, frightening, or particularly difficult events, including abuse, bullying, family conflict, or significant loss? You may provide a brief description here or discuss these experiences privately during an appointment.
_____
_____
_____

Has your child ever made statements of wanting to hurt themselves or to seriously hurt someone else? If so, please describe:_____
_____
_____

Has your child ever purposely hurt themselves or hurt someone else? If so, please describe:_____
_____
_____

Has your child ever experienced serious emotional loss, such as a death of, or physical separation from, a parent or caretaker? If so, please describe:_____
_____
_____

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INFORMED CONSENT / TREATMENT AGREEMENT

Welcome to Main Line Therapy Center. This contract contains important information about our professional services and business policies. It also contains summary information about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

COUNSELING SERVICES

Therapy is a relationship between people that is successful because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. However, there are no guarantees about what will happen in therapy. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Our initial counseling sessions will be 75 minutes and will involve a comprehensive evaluation of your unique needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work may include. At that point, we will discuss your treatment goals and develop an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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APPOINTMENTS

Your appointment time is reserved specifically for you. If you need to cancel or reschedule, please provide at least 24 hours' notice. Appointments canceled with less than 24 hours' notice, or missed without notice, will be charged the full scheduled session fee, except when an exception is agreed upon due to circumstances beyond your control.

PROFESSIONAL FEES

The initial 75-minute intake / evaluation session is $250. If we agree that we are a mutually good fit, each subsequent therapy session is $155 for 45 minutes, or $175 for 60 minutes. You are responsible for payment at the time of your session unless prior arrangements have been made. Payment may be made by check (payable to **Main Line Therapy Center**), cash, or electronically through Ivy Pay (secure payment system for Therapists). We are not able to directly process credit card payments. Any checks returned as unpaid are subject to an additional fee of $25.00 to cover bank fees. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge $175 per hour on a prorated basis for other professional services that you may require, including report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have health insurance, your policy will usually provide some coverage for mental health treatment. Upon request, Main Line Therapy Center will provide you with a medically-coded receipt for your therapy session with a diagnostic code that is required by most insurance plans for reimbursement. You may submit the receipt to your insurance company for reimbursement. It is your responsibility to know exactly what coverage your policy provides for mental health services and the process for getting reimbursed.

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PROFESSIONAL HEALTH RECORDS

By law, Main Line Therapy Center is required to keep appropriate records of the psychological services that we provide. Your records are maintained in a locked cabinet in a secure location. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file.

Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACT BETWEEN SESSIONS

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters. If you do not hear from me, or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please call the National Suicide Prevention Lifeline at **9-8-8**, or call **9-1-1** and ask to speak to the mental health worker on call. Main Line Therapy Center does not offer 24-hour emergency or crisis care. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

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LIMITS OF CONFIDENTIALITY

Psychotherapy is confidential, with the below stated exceptions.

Duty to Warn: Therapists are mandated by law to disclose pertinent information discussed in therapy if the client has an intent or plan to harm another person.

Suicide/Self harm: Depression is a common emotion expressed in therapy. If a client is feeling hopeless enough to imply or disclose a plan for suicide, steps need to be taken to ensure safety. This would include making reasonable attempts to notify the family and possible admission to psychiatric emergency services.

Animal abuse: I will report animal abuse, including cases of neglect and hoarding.

Vulnerable Adults and Children: Mental health professionals are required by law to report stated or suspected abuse of a child or vulnerable adult to the appropriate social service agencies.

Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

Other than the noted exceptions, if there are reasons to disclose your protected confidential information you understand that I will be provided a Release of Information form to make the request in writing.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope that you will talk with me so that I can respond to your concerns. Concerns will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social relationships with clients or with former clients.

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TERMINATION

Your participation in psychotherapy with Main Line Therapy Center is voluntary. You have the absolute right to withdraw and cancel treatment at any time. We will discuss and develop a termination plan to reduce any potential negative effects. If 3 consecutive scheduled appointments are missed, Main Line Therapy Center will consider your treatment canceled and you will be financially responsible for the fees associated with the missed appointments. A letter will be sent to you acknowledging the termination along with a closing bill for any unpaid balance.

AGREEMENT / CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement in its' entirety (including **LIMITS OF CONFIDENTIALITY**) and agree to all terms and conditions.

Client(s) Agreement:

Client Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Therapist Agreement:

Signature: _____ Date: _____

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