Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

NEW CLIENT REGISTRATION

Today's Date_____
Child's Name: _____ DOB: ___/___/____ Age: _____

Child's Primary Residence: _____ City: _____ Zip: _____
Caregiver (s) at this address: _____
Is it okay to send correspondence/billing to this address? Yes No If no, please provide an alternate address:
_____

Second Residence _____ City: _____ Zip: _____
Caregiver (s) at this address: _____

Relationship Status of Child's Parents: Married * Divorced * Separated * Widowed * Other
If divorced, what is the custody agreement? _____

Mother: _____
Occupation: _____
Employer: _____
Home phone: (_____) _____
Cell phone: (_____) _____
Email: _____

Father: _____
Occupation:_____
Employer: _____
Home phone: (_____) _____
Cell phone: (_____)_____
Email: _____

If applicable:
Step-Mother: _____
Occupation: _____
Employer: _____
Home phone: (_____) _____
Cell phone: (_____) _____
Email: _____

Step-Father: _____
Occupation:_____
Employer: _____
Home phone: (_____) _____
Cell phone: (_____)_____
Email: _____

Okay for therapist to email or text to the cell#'s listed above to confirm appointments? Yes No
Okay for therapist to leave a brief message on the phone numbers listed above? Yes No
Okay for therapist to send newsletter and practice updates to the emails above? Yes No

Referred by: Insurance Co. Physician Friend Google Ad Website Other:_____

May I have permission to thank the person that referred you? Yes No

---

Solutions 4 Kids
Linda Wiskerchen, LCSW
11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Informed Consent for Assessment and Treatment

The purpose of this document is to help you to make an informed decision about participating in treatment. Please read it carefully and discuss with me any questions that you may have. A copy of this form is available by request.

About the Therapy Process

It is important for you to know that child & family therapy has risks and benefits. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness, fear or loneliness and family distress or concerning behaviors may increase. However, therapy has been shown through research to be beneficial to adults, children, couples and families. Although there are no guarantees about the outcomes of therapy, families can experience improved closeness and communication and children and adolescents often demonstrate a reduction in concerning behaviors and an increase in emotional well-being. I utilize individual child therapy, play therapy, parent consultation, family therapy, social skill building, cognitive behavioral therapy, expressive arts therapy and relaxation/mindfulness skills in my work with children and families.

Parent involvement is an integral part of child therapy. Sessions may include parent involvement in the session, sometimes through talk and sometimes through an activity or play. When parents are willing to join their children in a playful manner, it can greatly increase the effectiveness of therapy sessions.

An important part of child therapy includes regular meetings with parents. These meetings are an essential part of your child's growth in therapy. During these meetings, we will discuss your child's progress in therapy, changes in behavior at home and school and your ongoing concerns. We may also discuss family history and family interactions as relevant to treatment. Consultation and psycho-education will be provided if needed.

If you have information that you want me to know before a session with your child, please email or call me 24 hours before the session so that I have time to receive the information and plan the session accordingly.

Custody/Guardianship

Consent for services can only be authorized by a current legal guardian. For divorced parents, consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. (A copy of the divorce decree must be included in the client file indicating the custodial arrangement). Permission from both parents, regardless of the custodial arrangement is the preferred practice of this office.

About Me

I am a private practitioner in this office and hold no formal or legal association to the other practitioners providing behavioral health services in this office/suite. I am licensed with the State of Arizona, Board of Behavioral Health Examiners, to practice independently as a Licensed Clinical Social Worker. I have a Masters Degree in Social Work.

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Client Rights

1. You have the right to ask questions about and/or refuse any therapeutic technique or recommended treatment and the right to be advised of the consequences of such refusal or withdrawal.
2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish, I will provide you with the names of other qualified therapists.
3. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.
4. You have the right to request your medical and billing records. Please see HIPAA form for procedure.

Therapy Services and Fees:

1. Session Fee: **A therapy hour is 50 minutes**. My standard fee is $**110 per 50-minute session.** I request payment of fee or co-payment at the time of service. If you are on a Health Plan for which I am a provider, I will bill your insurance company for you. Any deductibles or co-payments are due at the time of the visit. **Returned checks** will be charged a $25 fee. You are encouraged to schedule sessions as you feel will be helpful. I will recommend a schedule that I believe will be most beneficial for your goals.

2. **No-show/Late Cancel**: If you are unable to attend your scheduled appointment, you must call 24 hours in advance or you will be charged a **$60 late cancellation/no-show fee**. This is the client's responsibility, as insurance will not cover this.

3. Insurance Benefits**:** My office does call and check on Outpatient Mental Health Benefits. This is not a guarantee of payment and the insurance companies do state this before benefits are given. You are ultimately responsible for payment of Professional services rendered regardless of insurance coverage.

4. Other Fees: Most fees are billed at $110 hour in 15-minute increments. **Client phone calls**: Free for the first 10 minutes and then pro-rated at $110 hr. **All other phone calls and services** (i.e. consultation with a psychiatrist, reading extensive emails) charged at $110/hour. **Legal:** Any work related to a legal situation (i.e. attorney calls, writing reports & court appearances) ***will be billed at $250.00/hr*** (billed in 15 minute increments). **Refund**: If a client is due a refund, this will be provided by check or credit within 5 business days of therapist becoming aware of refund amount due. **Returned checks** will be charged a $25 fee.

Therapist Availability & Emergency Procedures

1. This practice does **NOT** have the capacity to respond to counseling emergencies. Emergencies should be directed to **911** or to the local **24-hour crisis line at (480) 784-1500.** If your child has a Psychiatrist, you should also contact him/her in times of emergent need.

2. You may leave a message at any time on my **confidential voicemail at (480) 861-9624**. I check messages frequently throughout the day and will return your call as soon as I am able. On weekends and holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 24 hours. If I haven't returned your call within 24 hours, please call again.

Solutions 4 Kids
Linda Wiskerchen, LCSW
11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

---

3. Email and text communication is for non-emergencies only. It may be used for appointment changes, referrals and non-clinical questions. I check emails as often as possible, but if you are canceling an appointment with less than 24 hours notice, please call the number listed above. I have no way to guarantee the confidentiality of electronic communication so please use at your own discretion. **All non-routine emails/texts will be printed out and kept as part of your permanent record.**

Confidentiality *(Please refer to HIPAA Notice for additional information)*

The confidentiality of all counseling interactions is protected by law. Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing, by signing a release of information form. There are certain situations in which, as a therapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required by law to inform you of my action in this regard. These circumstances include: medical emergencies; the existence of a threat of danger to self or others, reasonable suspicion of current child abuse, abandonment or neglect, dependant adult or elder abuse; a court order; third party billing claims requirements; receipt of a properly executed consent form; and where otherwise legally required (such as to comply with worker compensation laws, or to comply with the USA Patriot Act). The HIPAA Notice of Privacy Practices, posted in this office, on the website and available on request, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the HIPAA Notice may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates.

Parents are encouraged to respect their minor child's right to confidentiality. Parents can be assured that the minor will be encouraged to share critical information and that the parents will be given information regarding therapy themes and treatment progress.

_____ **(initial)** I have been informed of the limitations of confidentiality in terms of the treatment of a minor. I understand that special care and sensitivity may be required in releasing information to me about certain topics such as substance abuse and sexual activity. I accept Linda Wiskerchen's judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that if Linda Wiskerchen believes this minor is in danger of hurting him/herself, I will be notified immediately. In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts).

In the event of my death or incapacity, the records for my clients that are actively receiving services (seen within the past month) will be given to one or more local behavioral health professionals to facilitate continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying record requests and destroying records when the legal timeframes for records retention are satisfied.

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

It is common for licensed therapists to participate in consultation and training groups within the mental health community. I regularly consult with other professionals regarding my clients, however, my client's identity remains completely anonymous, and confidentiality is fully maintained.

Emails, Cell Phones and Faxes

Individuals may choose to contact me via email or cell phone. In doing so, they agree to the understanding that email and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell-phone/texts or faxes. If you communicate confidential or highly private information via electronic media, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.

Social Media

I do not accept friend/contact requests from current or former clients on any social networking site. I believe that adding clients as contacts can compromise your confidentiality and may also blur the boundaries of our therapeutic relationship. My primary concern is your privacy. Please note that I do not follow current or former clients on blogs or Twitter. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together.

Legal Disputes

I understand that this therapist is not conducting a custody or visitation evaluation for my child. I agree not to involve the therapist in any custody or visitation disputes as I understand that would not be in the best interest of my child's relationship with the therapist and would be counterproductive to the therapeutic process. I agree not to involve the therapist in court proceedings regarding any treatment of my child now or in the future, nor will the therapist be asked to share my child's records regarding any such proceeding. _____ **(initial)**

I authorize evaluation and treatment from Linda Wiskerchen, LCSW for myself and/or the child/children for whom I am legally responsible, and I agree to pay all fees for such treatment. I acknowledge that I have received a copy of this informed consent agreement and the HIPAA Notice of Privacy Practices (upon request). It is agreed that either of us may discontinue treatment at any time. I also authorize the release of my/our DSM-IV diagnoses code, at my request, to be printed on a claim form to submit to insurance for possible benefits.

Please **SIGN and PRINT** below:

Parent: _____ _____ Date: _____

Parent: _____ _____ Date: _____

Minor: _____ _____ Date: _____

Therapist: _____ Linda Wiskerchen,LCSW Date: _____

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

INTAKE QUESTIONNAIRE

Child's Name: _____DOB: _____Age: _____

Person completing form: _____

Please list **all those living in your home** besides the child. This includes spouse, siblings, partner, friends and relatives. *Please use the back of this form if needed.*

Name	Age	Gender	Relationship to Child
		□ M □ F	
		□ M □ F	
		□ M □ F	

Separation/Divorce:

Are parents separated or divorced? □ Yes □ No If yes, for how long? _____
If parents are separated/divorced, does non-custodial parent share legal custody? □ Yes □ No
Are both parents aware that this child will be receiving counseling? □ Yes □ No
Does child have contact with both parents? □ Yes □ No How often?_____

Counseling History

Has your child previously received counseling? Yes No If yes, when and for what?

_____

Do you think that it was a positive experience for your child? Yes No
Was it a positive experience for both parents? Yes No
Has your child received medication for behavior or moods? Yes No
If yes, what was the outcome?_____

Please complete the following questions:

How well does your child fall asleep, stay asleep and wake up from naps and in the morning**?**

_____

Does your child show any separation anxiety/fears at home or school? Yes No If yes, please describe: _____

_____

What is your child's favorite thing to do? _____
What are your goals for your child's therapy? _____

_____

_____

What is the most important thing that I can do for you today?_____

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Child's Name:_____

Medical History

Pediatric office: _____ Doctor: _____
Address: _____ Phone: _____
Does your child have any **current** or **past** medical or physical concerns? □ Yes □ No
If yes please describe: _____
Has your child had any of the following? If yes, please explain:
Head injuries? □ Yes □ No If yes, did child lose consciousness? □Yes □ No _____
Hospitalizations? □ Yes □ No _____
Surgeries? □ Yes □ No _____
Medical procedures? □ Yes □ No _____
Seizures? □ Yes □ No _____
Serious illness □ Yes □ No _____

☐ hearing difficulties ☐ eye/vision problems ☐ asthma
☐ sensory problems (i.e. doesn't want to touch certain textures; bothered by bright lights)
☐ fine motor problems (handwriting, cutting, using fingers)
☐ gross motor problems (clumsy, poor balance, trouble running)
☐allergies (food, pet, etc) □ Yes □ No If yes, what? _____

Current Medications: please add additional information on back if needed.

Name of Medication	Dose/frequency	Reason	How long prescribed	Prescribing Doctor

Prenatal/Birth History

Did mother receive prenatal care? □ Yes □ No
Were there any complications during: Pregnancy □ Yes □ No _____
Labor □ Yes □ No _____
Delivery □ Yes □ No _____
Was child born premature or full-term? _____ Vaginal or Caesarian?_____
Child's Weight at birth _____
Was there an extended hospital stay for mother or child after delivery? □ Yes □ No _____
Did child spend any time in the NICU? □ Yes □ No _____
Alcohol or drug use during pregnancy? □ Yes □ No _____
Use of medication during pregnancy? □ Yes □ No _____
Did mother have post-partum depression? □ Yes □ No _____

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Child's Name:_____

Please check any items below that your child experienced as an infant or toddler:

__ Exposure to lead
__ Walking/gross motor delay
__ Speech/Language delay
__ Hand coordination/fine motor delay
__ Poor attachment to parents/caregivers
__ Sleeping difficulties
__ Problems eating
__ Not wanting touch
__ Clingy
__ Repetitive movements
__ Difficult to comfort
__ Eating non-foods
__ Overly social/friendly
__ Slow response when called by name
__ Avoidance of eye contact
__ Separation from parents
__ Loss of previous abilities
__ Other _____

Please note any delays or concerns with following milestones:

Sitting _____ First word _____
Crawling _____ Two-word sentences _____
Standing _____ Toilet trained _____
Walking _____ Imitates others _____

Childcare

Childcare: _____Phone# _____
☐ center ☐ home daycare ☐ in your home ☐ before/after school ☐ friend/neighbor
☐ other_____ #Days/week:____ #hours/day: ___ # Children in facility:_____
Has child been asked to leave any childcare? ☐ no ☐yes

Education

School: _____Grade: _____ Teacher _____
Has your child attended other schools? ☐ No ☐ Yes : How many? _____
What prompted the change? _____
Overall, how is your child's academic progress? ☐ excellent ☐good ☐fair ☐poor ☐ struggling
Does your child receive any special services?
☐ tutoring (in school/ private) ☐ occupational/speech/physical therapy ☐ 504 plan ☐ IEP
☐ Other_____
Have you ever been called to pick your child up at school due to misbehavior? ☐ No ☐ Yes
_____
Has your child ever had detention, been suspended or asked to leave a school? ☐ No ☐ Yes
_____
Does child ever report not liking school or teachers? ☐ No ☐ Yes
Homework time is: Easy Moderately Challenging Difficult Impossible

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Child's Name:

Child and Family History - Please indicate any that child has experienced:

___ Parent injury/ illness/hospitalization
___ Unemployment of family member
___ Alcohol or drug abuse by family member
___Abuse (Sexual, emotional, verbal, physical)
___Violence in the home
___Violence in the community
___ Family members that have been arrested
___ Family members that have been incarcerated
___ Police confrontation/arrest of parent/guardian
___ Death in the family
___ Conflict between parents
___ Witness to drug abuse
___ Financial stress for caregiver
___ Exposure to a traumatic event
___ Car accident
___ Home robbery/invasion
___Disaster (natural/other)
___ Frequent moves

Family Mental Health History – *Family history is important to understanding your child's behavior and treatment. Please indicate below if anyone in the family has experienced the following.*

Has anyone experienced:	**Mother's Side**	**Father's Side**
Anxiety		
Depression		
Bipolar disorder		
Learning disorders (ADHD, dyslexia…)		
Drug abuse		
Alcohol abuse		
Schizophrenia		
Suicide attempts		
Completed suicide		
Panic Attacks		
Collecting useless items		
Violent temper		
Abuse (Physical/ Emotional/ Verbal / Sexual)		
Hallucinations or Delusions		
Strange behavior or thinking		

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Please check items that describe your child's behavior for the **6 months:**

□ Academic problems/homework difficulties	□ Nightmares, night terrors
□ Angry mood/Rages/Yelling	□ Paying attention; focusing difficulties
□ Anxiety	□ Perfectionism
□ Arguing	□ Playing with fire
□ Being bullied or bullying	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossiness	□ Unusual behavior
□ Confused thinking	□ Self injury
□ Crying frequently	□ Separation anxiety
□ Defiant (to parents or other adults)	□ Sexualized behavior (that seems inappropriate)
□ Destroys things	□ Shyness (excessive)
□ Disorganized, loses things	□ Sleeping, waking difficulties
□ Doesn't want to try new things	□ Somatic complaints (headaches/stomachaches)
□ Eating issues (too much, too little)	□ Stealing
□ Easily frustrated	□ Strong feelings of guilt or shame
□ Emotional outbursts	□ Suicide attempts
□ Fears	□ Suicidal thoughts (says wants to die)
□ Forgetfulness	□ Talking back
□ Frequent conflict	□ Tantrums
□ Grief/loss	□ Threats or comments about hurting self
□ Hair pulling	□ Threats or comments about hurting others
□ Hard to make/keep friends	□ Too concerned with neatness
□ Hears or sees things others do not	□ Toileting
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence	□ Withdrawn; not sociable
□ Learning and remembering difficulties	□ Worries a lot
□ Mood quickly goes up and down	□ Yelling

Solutions 4 Kids
Linda Wiskerchen, LCSW

11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Treatment Plan for _____ *(child's name)*

The main GOALS that I/We have for this child's therapy are:

1. _____
2. _____
3. _____

Therapist will complete this section with you:

Treatment Methods Include: Individual Child Therapy, Parent Consultation, Family Therapy, CBT, Psycho-education, Play Therapy, Expressive Arts Therapy, Relaxation/Mindfulness Skills

Attend session _____

Other Recommendations:
Couples/Family Counseling; Psychiatric Assessment; Follow-up with Medical Practitioner, OT asst
Other: _____

Plan to be reviewed on : ___/___/___

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____

Minor Signature _____ Date: _____

Therapist _____ Date: _____
Linda Wiskerchen, LCSW

Plan Reviewed: ___/___/___ [ ] Continue with goals above and/or [ ] Add new goal(s) below:

1. _____
2. _____
3. _____

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____

Minor Signature _____ Date: _____

Therapist _____ Date: _____
Linda Wiskerchen, LCSW

Solutions 4 Kids
Linda Wiskerchen, LCSW
11011 S. 48th Street Suite #101 Phoenix, AZ 85044
(480) 861-9624
www.Solutions4kids.org

Fee Payment Policy and Credit/Debit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file.
You may pay by cash or check, but a card must still be kept on file.****

Name on Card:

_____

I authorize Solutions 4 Kids, Linda Wiskerchen to charge my credit/debit card for professional services as follows**:**

- **To charge my card $60.00 for each no-show or late cancellation (less than 24 hours notice). Card will be charged on the day of the late cancellation/no-show unless other payment arrangements have been made.**
- All visits for which payment was not made at time of visit.
- The balance of fees not paid by client 30 days after a written billing statement has been issued to client.

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Credit Card Number _____ - _____ - _____ - _____ Expiration Date _____

Card Holder's Zip Code for Credit Card Statements:_____

CVV Number _____ (3 or 4 digit number usually found on the **back** of the card).

Card Holder Signature _____ Date ____ /_____ /____

Charges will appear on your credit card statement as ***Solutions 4 Kids*** *or some abbreviation of it.*