BETTY & BOBBY ALLISON
OZARKS COUNSELING CENTER
helping you find your way

614 South Ave
Springfield, MO 65806
Office: 417-869-9011
Crisis: 417-862-6555

Welcome to Betty & Bobby Allison Ozarks Counseling Center, we look forward to working with you. **Please read the following information carefully.** Feel free to ask any questions you may have at the initial intake. You are welcome to show this information to others in your family or to other professionals you trust.

TIME OF APPOINTMENTS: Each of our appointments is scheduled to last about 50 minutes. It is our policy to charge for a missed appointment without 24 hour notice, unless it was an emergency situation. If you consistently fail to keep your appointments we will refer you elsewhere for counseling. If you are set up with a standing appointment and fail to keep an appointment without notifying our office we will cancel any future appointments. You can still schedule with us, but may lose your standing appointment time.

SEE YOUR DOCTOR: If possible, we strongly recommend that you get a physical examination from your personal physician as soon as possible. This is important to make sure that none of the problems to be discussed are the result of physical health difficulties. Because we are not physicians, we cannot know if you have physical conditions that might be related to your situation.

EMERGENCY SITUATIONS: We will try to be available to you as much as possible. We are open Monday-Thursday 9:00-8:00, Friday 9:00-4:00, and Saturday 9:00-1:00. The telephone numbers on the front of this form are to the BBAOCC and the area 24 hour crisis line.

COST: It is our mission to make the counseling you need affordable. Your fee is discounted according to your household income and the number in the household. If your fee on the sliding scale is still not affordable you can request a grant form which may reduce your fee based on your expenses. Our basic rate is $80 per counseling hour before adjustment for income. Our sliding scale is made possible in part by United Way of the Ozarks funding as well as our use of Counselors-In-Training and graduate level interns, all of whom are supervised by our licensed staff members.

INSURANCE: Your health insurance *may* cover this service. Please provide your insurance card to the front desk at initial session. If we bill insurance for you we charge the $80.00 flat rate fee. Your fee if self pay is based on the sliding scale fee and you are responsible for the fee if your insurance does not pay. Medicaid/MC+ will pay for counseling if the client is under age 21. Medicare may also cover our counseling services, but we will need to verify coverage.

CONFIDENTIALITY: As a client, you have rights to confidentiality. Therapists are bound by ethical codes of their profession and under the privacy act laws of Missouri. Information shared with a therapist will be given to others only upon your request and with your written permission. Some limits on maintaining confidentiality are:

*Subpoena of records by a court of law.
*Laws mandating reporting of child or vulnerable adult abuse.
*Duty to warn the proper authorities regarding homicidal or suicidal concerns.
*Your diagnosis which is required on all health insurance forms.
*Special rules for Minors: under MO Law (431.061.4) Both parents have access to the minor's health (including mental health) records.

Child Intake Basic Information

Name of Child:_____ Today's Date:_____

Address:_____

City:_____ State:_____ Zip:_____

County:_____ Birthdate:_____

Age:_____ Gender:_____ Race:_____

List the persons with whom your child is now living with, ages, and relationship to him/her:_____

_____

Biological/Adoptive Father: (circle one) _____ Phone: _____

Address:_____

City:_____ State:_____ Zip:_____

Biological/Adoptive Mother: (circle one) _____ Phone: _____

Address:_____

City:_____ State:_____ Zip:_____

Step-Father: _____ Phone: _____

Address:_____

City:_____ State:_____ Zip:_____

Step-Mother: _____ Phone: _____

Address:_____

City:_____ State:_____ Zip:_____

Annual Gross Income for Household (includes child support, disability, retirement, etc.):_____

How did you find out about us? _____

Who has legal custody of the child or GAL assigned? _____

I would like to receive appointment reminders by (circle all that apply): Email Text None

It is ok to leave messages with the person answering the phone, answering machine, and/or voicemail: Yes No

Parent Email: _____

Insurance/Healthcare (optional)

Does your child have (please circle): Medicaid, Private Insurance *please present cards to front desk*

Clinic or physicians name:_____

Last Visit:_____ Reason:_____

Current Health Problems:_____

_____

Medications: _____

Previous Hospitalizations (reason/date): _____

_____

Previous Counseling:_____

Your Concerns

Briefly describe the reason for coming to counseling: _____

_____

Please check all areas that you are currently concerned about. Circle areas most important to your child now.

_____bullying
_____parenting
_____anger
_____depression
_____alcohol (self)
_____alcohol (others)
_____physical abuse
_____school
_____job/career
_____phobia/fears
_____assertiveness
_____seizures, black-outs
_____panic attacks
_____drugs (self)
_____drugs (other)
_____death
_____weight problems
_____eating disorders
_____sexual abuse
_____legal problems
_____step-family issues
_____sleep problems
_____grief/mourning
_____health
_____sexuality or LGBTQ
_____marriage preparation
_____cutting/self-harm
_____divorce adjustment
_____relationship problems
_____guilt
_____anxiety
_____suicide
_____hallucinations (audio/visual)
_____family
_____problems with parents
_____ obsessive thoughts
_____trauma victim
_____financial
_____head injuries

_____other: _____

Consent for Treatment

I hereby consent to assessment, treatment, counseling, and/or family therapy for myself, my child, or legal ward as deemed appropriate by the staff of the Betty and Bobby Allison Ozarks Counseling Center. My signature indicates that I *understand the information as provided to me on the information sheet* I received with this consent form.

I give permission for this agency to release information necessary to bill Medicaid, Medicare or private insurance for services rendered by BBAOCC.

I understand it is my responsibility to notify any other parents or legal guardians that my child is receiving counseling services at BBAOCC.

I understand that the counselor's role is to benefit the child and every effort will be made to limit involvement in parental conflict. I agree that I am not attempting to gain advantage in any legal proceeding between myself and another parent/guardian by bringing my child to counseling.

Court appearance fee is a minimum of $200 per hour. There is no additional fee to provide a report regarding your counseling here, provided you have signed off on a Release of Information.

_____ _____

***Signature** ***Relationship to Child**