

# Heloisa H. Portela, Ph.D., LPC, NCC, ACS

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## Consent to Treatment

Client: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I do hereby seek and consent to take part in (or allow my child to receive) treatment by Dr. Heloisa H. Portela, LPC. I understand that developing a treatment plan with this health care provider and regularly reviewing our work toward meeting the treatment goals are in my (or my child's) best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the health care provider. I know that I may stop treatment with the health care provider at any time.

I acknowledge that keeping of regular appointments is the most effective means of scheduling therapy. I understand that the time scheduled for the therapy appointment is reserved exclusively for me/my child. In light of this, appointments should be kept. If for some reason there is a need to cancel an appointment, **I will call Dr. Heloisa Portela with 48 hours in advance.** I understand that I will be charged for sessions that are not canceled 48 hours prior to their schedule time (be aware that insurance companies do not reimburse these).

I am aware that payment for each session is due at the time the session is held. I also understand that I have the option to use my health insurance in order to cover the counseling treatment fee. My health care provider can be responsible for filling the bill directly with my health insurance for the services she provides. In such instances, my health insurance company may inquire about the type(s), cost(s), date(s), and information of any services or treatments I/my child receives. My therapist will need a copy of the insurance card in order to do this.

It is my responsibility to bring my current insurance card to Dr. Heloisa Portela when a new card is issued, to confirm that they have out-of-network counseling benefits, and double check the co-pay value for each session. If my insurance coverage ends or lapses for any reason or if it does not cover the services provided, I will be responsible for full payment of services. The fee for each session (45-50 min.) is \$125.00. A discount may be given to clients who opt to file insurance for themselves or who pay out-of-pocket for their treatment.

By signing this form I am agreeing to let my healthcare provider use my or my child's information in order to fulfill billing issues. The Notice of Privacy Practices explains in more detail my rights and how my healthcare provider may use and share information. **If I decline to sign this consent form agreeing to what is in the Notice of Privacy Practices, I can not receive treatment.**

I have had a chance to discuss all of these issues, and the risks and benefits of treatment. I have also read and understood the Notice of Privacy Practices.

**My signature below shows that I understand and agree with all of the above statements.**

\_\_\_\_\_  
Signature Of Client or Legal Guardian

\_\_\_\_\_  
Date

I, the health care provider, have discussed the issues above with the client (and/or his or her legal guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature Of Health Care Provider

\_\_\_\_\_  
Date

*This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.*

# Child Information Sheet

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Pager #: (\_\_\_\_) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Children (names and ages): \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

## **Medical Information:**

Physician(s): \_\_\_\_\_

Phone #(s): \_\_\_\_\_

Any Medical Problems: \_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

Previous Mental Health Consultations, Evaluations, or Treatment: \_\_\_\_\_

## **Referral:**

Who referred you to this practice: \_\_\_\_\_

Any other reason for consulting specifically with this practice? \_\_\_\_\_

\_\_\_\_\_

## Medical/Mental Health History

What is the major reason for you to seek counseling for your child at this time? When did the issue start?

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Has your child had prior counseling? If so, when and with whom?

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Has your child suffered any serious accidents/injuries/illnesses? Please explain below. Please circle if it involved: convulsions, high fevers, loss of consciousness, fainting, headaches, allergies, chronic fatigue, head injuries, ear problems, meningitis.

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Has your child ever required hospitalization or been treated for serious illness or disease? If so, please explain:

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Current Internist/Family Practitioner's name and name of practice:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

When was your child's last complete physical? \_\_\_\_\_

Does your child currently have any health problems?

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Is your child currently on any medications? If so, please list what they are and what the medication is treating?

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Briefly describe any medical history you feel is affecting your child's well being:

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Describe your child's current use of alcohol/drugs.

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Has your child ever been treated for substance abuse? If so, when, where, and for what substances?

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Is there a family history of mental illness or substance abuse? If so, please explain.

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Has your child been sexually abused or do you worry he or she may have been? \_\_\_\_\_

Briefly describe any trauma that your child may have suffered (including physical, emotionally, sexual abuse):

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Have there been domestic violence issues in the home where your child grew up/live? \_\_\_\_\_

Has your child ever attempted suicide or had a plan to harm himself or herself? When?

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Does your child currently have any known thoughts or feelings of wanting to physically harm himself or herself? Please describe.

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Has your child ever been diagnosed with an eating disorder? If so, please describe.

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Has your child's eating and/or sleeping habits changed in the last 3 months? Please describe.

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Please list your child's significant and positive life influences:

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Please list your child's significant life traumas and the year they occurred:

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Your child's school name: \_\_\_\_\_ Grade: \_\_\_\_\_

Please describe your child's current academic functioning. How are his or her grades?

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Does your child have friends? Does he or she know how to have fun?

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What does your child like to do?

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What is your child good at?

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What are your goals for your child's counseling?

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Please add any other information about your child that would be helpful for the counselor to know.

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## Your Child's Family

Mother's name, nickname, country of origin and educational background:

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Information about mother's general health, were there any physical, learning or emotional problems?

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Mother's religious/spiritual affiliation (if any):

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Mother's work experience (if any outside the home):

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Father's nickname, country of origin and educational background:

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Information about father's general health, and were there any physical, learning or emotional problems?

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Father's religious/spiritual affiliation (if any):

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Father's work experience (if any outside the home):

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Is your child adopted? If so, please give any relevant information about biological parent history:

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Brothers/Sisters:

Name	Biological? Yes/No (Explain)	Date of Birth	Current Age	M/F	Grade	Health Status
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Please list anyone else who lives or lived with your child or was a memorable caretaker in his or her life:

Name	Current Age	Relationship to Child	Health/Problems
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\_\_\_\_\_  
 \_\_\_\_\_  
 If you and the other parent of your child are still partnered, for how long have you been together? \_\_\_\_\_  
 If married, since when: \_\_\_\_\_ If separated or, since when: \_\_\_\_\_ If divorced or, since when: \_\_\_\_\_

If separated, divorced or other parent has died, please explain the circumstances.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If separated/divorced, please explain custody & visitation schedule (if any) and communication status between you and former spouse.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please give a brief history below as to when you and the other parent of your child first met, and any relevant information about your years together (what life crises or challenges or joys you both have experienced).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list anyone else who lives with your child:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list is anybody who is a memorable caretaker in your child's life:  
 \_\_\_\_\_  
 \_\_\_\_\_

Who lives in the same house as your child?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Symptoms & Characteristic List**

Please check the box in front of any word or phrase you feel applies to yourself:

<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Problems at Work	<input type="checkbox"/>	Disabled
<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Problems at School	<input type="checkbox"/>	Body pains and aches
<input type="checkbox"/>	Sad	<input type="checkbox"/>	Social Problems	<input type="checkbox"/>	Low motivation
<input type="checkbox"/>	Hyperactive/Agitated	<input type="checkbox"/>	Marital Problems	<input type="checkbox"/>	Low energy
<input type="checkbox"/>	Manic	<input type="checkbox"/>	Relationship Problems	<input type="checkbox"/>	Cannot keep a job
<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Legal Problems	<input type="checkbox"/>	Don't take vacations

Poor Concentration	Sexual Problems	Cannot make decisions
Memory problems	Fainting spells	Financial problems
Impulsive	Crying Spells	Compassionate
Reckless Behavior	Lonely	Passionate
Aggressive	Fearful	Happy
Disturbing thoughts	Nightmares	Shy
Problems With Daily Living	Thoughts of Hurting Self	Naïve
Sleep Problems	Thoughts of Hurting Others	Unattractive
Eating Problems	Restless	Worthwhile
Binge eating	Empty feelings	Friendly
Vomiting	Fatigued	Lovable
No appetite	Tense/ Nervous	Intelligent
Medical Problems	Controlling	Considerate
Regular Alcohol Use	Jealous	Attractive
Drug use	Misunderstood	Diplomatic
Addicted	Bored	Cold
Addictive Personality	Regrets Past Actions	Angry

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor (when applicable). I understand that I am financially responsible for any balance. I also authorize Dr. Heloisa Portela or my insurance company to release any information required to process my claims.

X \_\_\_\_\_  
 Parent/Guardian Signature Date