FORM 01b - INTAKE FORM FOR MINORS

Date of Intake | Client ID

CLIENT'S NAME: First Name | Middle Name | Last Name

AGE | DATE OF BIRTH | GENDER | CIVIL STATUS | RELIGION

Name of Person Completing this form (if other than client) | Relationship to Client

Complete Address:

CONTACT INFO Mobile Number | E-mail Address

EDUCATIONAL INFORMATION:

Grade/Level:

School/University:

EMERGENCY CONTACT *(In case of emergency, please contact)*:

Name:

Relationship: Contact #:

REASON FOR VISIT/PRESENTING PROBLEM:

CASE BACKGROUND: *(Kindly write, in short paragraph, the details of the case/problem)*

Please check behaviors and symptoms that you have observed.

- ☐ Aggression
- ☐ Addictive behaviors
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Chest pain
- ☐ Cyber addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating problems
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Hallucinations - Auditory
- ☐ Hallucinations - Visual
- ☐ Heart palpitations
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory problems
- ☐ Mood shifts
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Recurring thoughts
- ☐ Self-harm
- ☐ Sexualized Behaviors
- ☐ Sick Often
- ☐ Sleeping problems
- ☐ Sleepiness/Oversleeping
- ☐ Speech problems
- ☐ Suicidal thoughts
- ☐ Thoughts disorganized
- ☐ Trembling/Tension
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other: _____

Referred by: Contact No.:

Address/Institution of Referring Person:

Reason for Referral:

Welcome to the **Argao Psych**. Please read the following information and this whole document carefully as it contains important information about the nature of services, payment and fees, practical information, privacy and use of information, and limits to confidentiality. After reading this Agreement, please sign your name below to accept the terms of this Agreement.

CONSENT AND AGREEMENT FOR PSYCHOLOGICAL SERVICES

I, _____, of legal age and accompanied by my parent or guardian _____, accept and unconditionally agree to avail and undergo the different psychological services provided by the **Argao Health Inc.** doing business as **Argao Psych** (the "Company"). I also state that in personally signing (or my parent/guardian signing on my behalf), I state that I/we understand the following provisions:

A. **Nature of Psychological Services**. The Company, through its mental health service providers, will provide the psychological services, such as but not limited to psychological counseling, psychotherapy, psychological assessment, consultation, and intervention programs, within its facilities and premises or through its telepsych platform. The psychological services I will avail are bound by terms and conditions which will be explained prior to the start of the service, and that the Terms and Conditions and Privacy Policy of the Company become part of this Agreement.

B. **Schedule and Appointments.** The Company provides its services on a by-appointment basis. Should I decide to change or cancel my appointment, I can do so at least 10 hours prior to my appointment. Failure to do so or to communicate with the Company will be marked as 'Did Not Appear or No-show'. The Company reserves the right to charge fees for rescheduling or cancellation. If I am late, the session will still end at the booked schedule, however, the mental health service provider has the right to terminate the session if I don't arrive within 15 minutes of my appointment.

C. **Emergency Care and Crisis Situation**. The Company is not able to provide emergency care services for psychological or psychiatric emergencies. Individuals who are experiencing emergency situations, especially those in need of psychiatric medications, must seek psychiatric help available in other mental health facilities. Individuals who are in a crisis may be provided minimal interventions available to restore normal functioning. The Company may divulge information to a family member or other health care professionals regarding this situation.

D. **Payment and Fees**. The fees for the psychological services that I will avail will be discussed to me prior to the start of the service and that I agree to pay the said fees based on terms specified in the service contract. For individuals who wish to use payment gateways and our online services, full payment of fees is required prior to the start of the service. Pre-Paid Sessions are only valid for One Calendar Year from the date of payment.

E. **Termination of Service.** I have the right to terminate the services any time. I shall inform the Company in writing should I decide to terminate the services. The Company has the right to discontinue the services for any appropriate reason, including but not limited to, repeated lateness, excessive cancellations, and multiple 'Did Not Appear' or 'No-show' status. In such cases, I, or my personal representative, agrees to accept full responsibility for pursuing alternate professional mental health care.

F. **Social Media Policy**. Some clients wish to invite mental health services providers to be friends on Facebook, Instagram, Twitter, or other social networking sites. Unfortunately, mental health services providers are unable to accept requests of this kind. We feel your privacy and confidentiality are better protected if mental health services providers are not part of your online social network. In addition, this creates appropriate boundaries in the therapeutic relationship in which you are able to communicate important aspects of your life to your mental health services provider, rather than the mental health services provider reading about your life online. It also keeps mental health services providers' lives private and separate from therapy, so that the focus remains on you and the reason(s) you wish to attend treatment. Please feel free to discuss any questions/concerns about this policy with your mental health services providers.

G. **Recording of Sessions.** Service providers may conduct audio and/or video recording of the sessions, with the consent of the client. Similarly, clients are not allowed to record sessions through any means without the consent of the service provider.

H. **Limited Liability.** I absolutely relieve the mental health service provider and the Company from any responsibility or liability as witness or as defendant, in connection with the services I avail, in any proceedings in court or in any administrative agency where said psychological services and/or assessment results may be used in evidence for whatever nature or purpose, UNLESS when the services are specifically provided for the said purpose.

I. **CCTV Systems**. Closed-Circuit Television (CCTV) Cameras are installed in the Company's facilities in compliance with the City Ordinance # 2018-029 that mandates all establishments to install CCTV systems. Access to the CCTV recordings is restricted to the Company's personnel and to legal authorities for purposes as required or permitted for by law.

Signature over Printed Name of Client	Signature over Printed Name of Parent or Guardian	Date

LIMITS OF CONFIDENTIALITY

The contents of a consultation, intake, assessment, counseling, or psychotherapy session are considered CONFIDENTIAL. Verbal information and/or written and digital records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of Argao Health Inc. not to release any information about a client without a signed release of information. However, we are legally and ethically allowed to break confidentiality in the following circumstances:

1. **Duty to Warn and Protect.** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases when the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
2. **Abuse of Children, Women, and Vulnerable Adults.** If a client states or suggests that he or she is abusing or has recently abused a child, woman, or vulnerable adult, or that a child, woman, or vulnerable is in danger of abuse, the mental health professional is required to report this information to the appropriate legal authorities. We may also disclose information on reasons provided for Section 21 of R.A. 9262 or the Anti-Violence Against Women and Their Children Act of 2004.

DISCLOSURE OF INFORMATION

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. ONLY clinical information about the client is discussed.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be kept separate. The material disclosed in conjoint family or couples' sessions, in which each party discloses such information in the other's presence, is kept in each file in the form of case notes.

In the event that Argao Psych or its mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Likewise, if the Company must engage the services of a third-party agent to collect unpaid fees, the Company ensures that only information related to billing and fees will be disclosed.

PRIVILEGED COMMUNICATION

Argao Health Inc. and its service providers and personnel have protected rights to privileged communication, as stated for in Article VII Section 30 of R.A. 10029 or the Philippine Psychology Act of 2009: "*Rights to Privilege Communication for Psychologists and Psychometricians. – A psychologists or psychometrician cannot, without the consent of the client/patient, be examined on any communication or information disclosed and/or acquired in the course of giving psychological services to such client. The protection accorded herein shall extend to all pertinent records and shall be available to the secretary, clerk or other staff of the licensed psychologist or psychometrician. Any evidence obtained in violation of this provision shall be inadmissible for any purpose in any proceeding*."

PRIVACY NOTICE

Argao Health Inc. collects personal information and health information for the purposes of providing the services availed by the patients or clients. All information we collect are stored in secured databases and filing systems and are accessible only to authorized individuals. For more details, you may read the Privacy Policy at *www.argaocenter.com/privacy-policy*.

I agree to the above limits of confidentiality and the policies on the disclosure of information and privileged communication. I state that I understand their meanings and ramifications. I also consent to the use of my personal information and data and agree to the Company's Privacy Policy.

Signature over Printed Name of Client	Signature over Printed Name of Parent or Guardian	Date

USE OF CLIENT INFORMATION IN OUTCOME RESEARCH

Client information is often used to evaluate the effectiveness of types of therapy, treatment procedures, the therapist, and/or other factors in which a more careful study may help in the delivery of mental health services. Client names are not used when client information is evaluated for outcome evaluation purposes.

I agree to allow data from my record (not my name) to be used for outcome purposes.

Signature over Printed Name of Client	Signature over Printed Name of Parent or Guardian	Date