CPH Mental Health Counseling
737 Delaware Ave.
Suite 216
Buffalo, NY 14209
www.cphpsych.com

Welcome to CPH Mental Health Counseling!

Choosing a therapist is a big decision because working with someone you trust is an important step in reclaiming your life and maintaining your wellbeing. We are happy you have chosen CPH Mental Health Counseling to help you with your journey. We look forward to cultivating a positive and therapeutic relationship with you in working towards positive mental health goals.

We do not accept insurance. Why? We feel we can offer you better care and more privacy outside of insurance. Excellent care takes time. If we accepted insurance plans, we would not be able to achieve these goals as well as we do. We also respect your privacy and insurance companies will ask for access to your records. Often, clients want to keep information they share here private. Additionally, we are a small office and can keep your fees reasonable in part because we are not trying to negotiate payment with insurers. Many patients can use their health savings account for session payments or request a monthly billing statement from us to submit to their insurer for reimbursement.

Thanks to the generous grant from the Children's Growth Foundation, we are able to offer a sliding scale based on household income to our patients in need of financial support seeking gender and/or sexuality counseling. If you would like to have your session fee based on your **total household income**, please provide your entire household's most current W2's or last 4 paystubs. If you are divorced or separated and your child splits time between homes, both parents' incomes must be submitted.

If we do not receive income documentation, we will assume you will not be applying for assistance and that you will pay the **full fee of $150 per session**. The sliding scale is as follows:

Sliding scale session fees based on household income per year	
$75.00 (with card $77.59)	$30,000 and under
$100.00 (with card $103.35)	$30,001 - $50,000
$125.00 (with card 129.11)	$50,001 - $75,000
$150.00 (with card $154.87)	$75,001 and over

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We accept cash, check, money order, or card (Healthcare HSAs and FSAs are accepted as well). Please note, cards will incur ~3.5% convenience fee (see above fees). Your bank statement will reflect Danielle Cook Mental Health Counseling, PLLC. All checks and money orders must be made payable to Danielle Cook.

Please fill out all paperwork and return it to the office so that we may schedule you an intake appointment. Once we receive your information and your intake payment or card information, we will call to set up an intake appointment.

Sessions are 45 minutes long and we offer both in person and tele-sessions. Session payments are due at the time of your scheduled session. Please be advised we reserve the right to cancel your session if we have not received your session payment. We require a minimum of 24-hour notice when canceling or rescheduling appointments or you will be charged your full session fee. If we have not received check, cash, or money order payment by the time of your session, your card will be charged before the session can begin.

If you have any question about any of the forms or policies in this packet, please call out office at (716) 322-6394.

Thank you for choosing CPH Mental Health Counseling!

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GENDER DYSPHORIA AND SEXUALITY COUNSLING

New Patient Information
Child and Adolescent Form (17 and under)

Patient's Legal Name:

_____

Patient's Preferred Name and Pronouns:

_____

Primary Address:

_____

_____

Patient's D.O.B.: _____/_____/_____ Patient's Age: _____

Contact for *scheduling*: _____

Cell Phone: _____

Relationship to patient: _____

Email for **Client Portal** (**Please print clearly. This is the email that will be used to access all patient tele sessions**):

_____

Who is the responsible party for *billing*: _____

Cell Phone: _____

Relationship to patient: _____

Email (**Please print clearly**):_____

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Referral Source: _____

Are you interested in sessions: In-person _____ Tele-Health_____

School Information:

Name of School: _____

Grade: _____

Learning difficulties: _____

Father Contact Information: Same as Above YES / NO

Name: _____

Address: _____

Phone(s): _____

Email: _____

Employer: _____

Mother Contact Information: Same as Above YES / NO

Name: _____

Address: _____

Phone(s): _____

Email: _____

Employer: _____

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Medical Diagnoses (If Applicable):

_____

_____

Diagnosed by: _____ **When?** _____

Mental Health Diagnoses (If Applicable):

_____

_____

Diagnosed by: _____ **When?** _____

Current Medication and Prescriber:

_____

_____

_____

Psychiatric Hospitalization (include dates and locations):

_____

_____

_____

Other Mental Health Providers your child is currently seeing:

_____

_____

_____

_____

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Past Mental Health Providers your child has seen and the reason why:

_____

_____

Reason(s) for coming to CPH Mental Health Counseling?

_____

_____

_____

_____

Patient Concerns (Check ALL that apply):

General Counseling specifically for:

Depression ☐ Anxiety Disorder ☐ Post Traumatic Stress Disorder (PTSD) ☐

Obsessive-Compulsive Disorders (OCD) ☐ Life Changes ☐ Family Conflict ☐

Other:_____

_____

Gender Identity/Gender Dysphoria ☐

Trauma ☐

Sexuality/Orientation Concern ☐

"Coming Out" Concern ☐

Differences of Sex Development (DSD's) ☐

Sexually Inappropriate Behavior ☐

Sexual Fetish ☐

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When did your problem first start?_____

Within the last:

- ☐ 30 days
- ☐ 6--12 months
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

What areas of your child's life have been affected because of this problem?

_____
_____
_____

Is your child currently experiencing anxiety, panic attacks or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas your child has experienced:

_____

_____

_____

_____

What significant life changes or stressful events has your child experienced recently?

_____
_____
_____

What would you like your child to accomplish out of their time in therapy?

_____
_____

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What is your gender identity? (Check ALL that apply):

- Male
- Female
- Transgender Male/Transman/FtM
- Transgender Female/Transwoman/MtF
- Nonbinary
- Gender non-conforming
- Gender Queer
- Other (please specify): _____

What pronouns do you prefer that we use when talking? (Check ALL that apply):

- She/her/hers
- He/him/his
- They/them/theirs
- Other (please specify): _____

Sexual Orientation (Check ALL that apply):

- Straight
- Gay
- Lesbian
- Bisexual
- Unknown
- Other: _____

What sex were you assigned at birth? (Check one):

- Male
- Female
- Intersex

Have you ever had gender counseling before? Yes / No
Location and counselor's name: _____
_____

Have you been diagnosed? Yes / No

Have you ever been on cross-sex hormones? Yes / No

Are you currently on cross-sex hormones? Yes / No
If yes: Prescribed by: _____
Medication and dosage: _____

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*****If your child is currently taking hormones that are *not* prescribed, please describe below:**

At what age did they begin? _____

Please describe your child's gender experience:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Family History

Where was your child born? _____
Where they grow up? _____

Please list your child's parents and siblings

Name	Age	Relationship	Where do they live now	If deceased, age and cause of death

In the section below identify if there is a family history of any of the following.
If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List family member
Alcohol/Substance Abuse	Yes/ No	
Anxiety	Yes/ No	
Depression	Yes/ No	
Domestic Violence	Yes/ No	
Sexual Abuse	Yes/ No	
Eating Disorders	Yes/ No	
Obesity	Yes/ No	
Obsessive Compulsive Disorder	Yes/ No	
Schizophrenia	Yes/ No	
Suicide Attempts	Yes/ No	
Other diagnosed mental health condition?	Yes/ No	

How would you rate your child's current physical health? (Circle one)
Poor Unsatisfactory Satisfactory Good Very Good

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Please list any specific health problems your child is currently experiencing:

_____

_____

How would you rate your child's current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Which phase of sleep is your child experiencing issues?

Falling asleep Staying asleep Awakening early Sleep apnea

Please list any other specific sleep problems your child is currently experiencing:

_____

Please describe current use of alcohol, cigarettes, vape, and/or recreational drugs your child is engaging in:

_____

_____

_____

Please describe previous use of alcohol, cigarettes, vape and/or recreational drug history:

_____

_____

_____

_____

What does your child do in their free time? _____

How do they relax? _____

Do you consider yourself to be spiritual or religious? _____

If yes, please describe your faith or belief: _____

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What do you consider to be some of your child's strengths? _____

_____

What do you consider to be some of your child's challenges? _____

_____

Additional Concerns:

_____

_____

_____

_____

_____

_____

_____

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Office Policies

- **All session payments are due by the time of your scheduled session. We accept cash, check, money order, or card (Healthcare FSAs are accepted as well). Please note, cards will incur ~3.5% fee. Your bank statement will reflect Danielle Cook Mental Health Counseling. A card is required to be on file. All checks and money orders must be made payable to Danielle Cook (Please do not make them out to CPH).** Please be advised, we do not accept partial payments. If you are unable to pay your full appointment fee by the time of your session you will not see a therapist. If we have not received check, cash, or money order payment by the time of your session, your card will be charged before the session can begin.

- We require a minimum of 24-hour notice when canceling or rescheduling appointments or you will be charged for your full session fee. This policy is strictly enforced.

- A $10 late fee is applied for any payment that is not received within 3 days of the scheduled appointment. Clients with outstanding invoices that exceed the service due date are subject to an additional fee of $10 for every 30 days past due.

- If you would like to apply for our sliding scale, you are required to provide your entire household's most current W2's or last 4 paystubs to verify **total** household income. If you are divorced or separated and your child splits time between homes, both parents' income must be submitted. Income verification is required annually and there may be requests to update your information though out the year if the client is receiving financial assistance from our Foundation. If you would prefer not to provide this information the rate is $150.00 per session.

- Return fees are $40.00 per check/transaction.

- Future appointments cannot be made if a client has an outstanding invoice(s) on file. Once payment(s) is/are received, additional appointments can be made.

- Failure to pay any outstanding invoice within 90 days will result in termination of services.

Sign Date

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Tele-Therapy Policies

Session Link: Each session has a unique HIPAA compliant link via the TheraNest Client Portal. When your intake session is scheduled, you will be emailed the link to sign up for the TheraNest Client Portal, this login is how all tele-sessions will be accessed, **we recommend bookmarking the link**. If your email changes, please notify the office right away to avoid technical failures and to ensure you receive all necessary communications.

Session Structure: Tele-sessions are 45 minutes long and begin at the top of the hour. Please be ready for your session on time. If you have not logged on to your session after 15 minutes, the session will expire, and you will be charged your **full session fee.**

Session Connection: If using a desktop, laptop, cell phone, or tablet, be sure to access your portal using **Google Chrome** for the best connection results. Please make sure you have a strong internet connection and that you have turned on your audio and video before the session begins. You can use the link in your reminders to get to the session or just login to the Client Portal and go to appointments.

Session Privacy: We would like to remind patients that tele-therapy is just like a session in the office, therefore, the patient should be in a private setting with headphones on to ensure privacy. If the clinician feels the session is not secure, and that other people are listening or interrupting, the clinician has the right to terminate the session.

Cancelation Policy: Our cancelation policy requires a minimum of 24-hour notice for changing or canceling an appointment. Appointments that are not canceled or rescheduled within that timeframe will be charged their **full session fee.** This policy is strictly enforced. To make appointment changes, please call our office at (716) 322-6394.

Technical Difficulties: Our office is not responsible for technical difficulties. If the patient chooses to use TheraNest and is unable to connect or is experiencing internet difficulties, the patient is financially responsible for the session. If the patient is experiencing technical difficulties, it is their responsibility to call the office and notify us of the connection issue.

Session Payment: Please mail your payment before your session so that we receive your payment in a timely manner. If we receive your payment more than 3 days after your session, a $10.00 charge will be applied. Payments can be **mailed** to:

CPH Mental Health Counseling
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Buffalo, NY 14209

Checks and money orders are made payable to: Danielle Cook

Sign Date

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CREDIT CARD / ACH PAYMENT AUTHORIZATION

☐ - **Recurring Charge -** You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below **the day of each session**. A receipt for each payment will be emailed to you via TheraNest and the charge will appear on your credit card or bank statement showing the name Danielle Cook Mental Health Counseling. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 1 day prior to the payment being collected.

I, ________________________, authorize CPH Mental Health Counseling (DBA Danielle Cook Mental Health Counseling) to charge my credit card $__________ the day of each session. **This payment is for Counseling Services with Danielle Cook and includes the ~3.5% convenience fee for paying with a credit card.**

- -

Billing Information

Name as it appears on card: ____

Card Number:____

Exp Date:____

CVV:____

Billing zip code: ____

I understand that this authorization will remain in effect until I cancel it in **writing**, and I agree to notify CPH Mental Health Counseling in **writing** of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that CPH Mental Health Counseling may at its discretion attempt to process the charge again within 30 days, and agree to an additional $40 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

AUTHORIZED SIGNATURE ____________________________ DATE _____________

PRINT NAME ____

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ATTENTION

CHECK TO SEE IF ALL INFORMATION IS INCLDUED BEFORE SENDING:

- Completed Intake Paperwork

- Signed and dated Office and Tele-therapy Policies

- First Session Payment check/cash/money order is included with packet or card info has been filled out and authorization form has been signed.

Make checks and money orders payable to: **Danielle Cook**

Completed packets can be mailed to:
CPH
Attn: INTAKE
737 Delaware Ave., Suite 216A
Buffalo, NY 14209