

**Initial Intake Evaluation**

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

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

Preferred name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Home/cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to leave message or text Y/N

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: Hispanic or not Hispanic

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18yrs old: School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade or Highest Grade completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special ed. Y / N

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardianship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family members/current living situation:**

Name Age Gender Relationship Living where?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Emergency information:**

Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Emergency contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Insurance:**

\* Primary policy:

Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Secondary policy

Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interview**

Presenting problem: What situations led to you coming in for services?

(onset, duration, intensity)

Behavioral / cognitive reactions to the problem:

Client’s strengths and limitations:

Client’s baseline functioning:

-List any physical limitations:

-Identify some thinking stressors:

-Are there any difficult behavioral patterns or issues of concern?

**Crisis concerns**

What does a crisis look like for you? (psychological/behavioral indicators?)

-List some significant stressors in your life:

-Are there any warning signs, or behaviors to indicate crisis onset?

-What are some ways you can cope, prevent or manage a crisis?

-Who are some individuals you can contact in a crisis situation and how can they help?

Allergies:

Relevant medical / physical conditions / treating physician (major illness and/or hospitalization):

Current medications (include name of medication, dosage and if they are working):

Past psychiatric history: mental health/substance abuse/inpatient or outpatient hospitalizations or residential care:

Family mental health history:

Family substance abuse history:

**Psychosocial information**:

Marital history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual beliefs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Abuse Assessment**  (all clients 12yrs +) (amount, frequency, first use, last use, etc.)

Alcohol use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug use (illicit/prescriptive): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nicotine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk assessment**

Suicidal ideation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homicidal ideation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past suicidal/homicidal attempts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-compliance with treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic violence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Access to weapons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intervention and referrals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood and adolescent developmental history (including birthplace):

Prenatal history (pregnancy/labor/delivery issues, mother’s use of medication/alcohol/drugs, prenatal care):

Brief parental history:

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**CLIENT AND THERAPIST AGREEMENT**

**Welcome!**

Community Centered Counseling Services would like to take this opportunity to acquaint

you with information relevant to treatment, confidentiality and office policies. Please be aware that your therapist may not be currently licensed at the independent level, in which case a fully licensed mental health professional will closely supervise treatment and this paperwork associated with services provided by this agency. Participation in treatment through this agency is voluntary. If the client’s needs would be better served by another agency due to specialized needs, a referral will be discussed and contact information provided whenever possible.

**Aims and Goals:**

The major goal of your therapist and our staff is to help you identify and cope more

effectively with problems in daily living and to deal with inner conflicts which may disrupt

your ability to function effectively. This purpose is accomplished by:

a. Increasing personal awareness,

b. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.

a. Identifying personal treatment goals.

b. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment.

You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. The client/family will not attend sessions under the influence of alcohol or drugs. The client/family understands that the effort put forth in treatment is their responsibility and not that of the therapist.

You may be asked to complete questionnaires or to do homework assignments. It is our belief that a major part of therapy takes place between sessions, based upon your use of therapeutic interventions, such as coping and life management skills outside of the therapy session. We have reviewed intake paperwork and concluded that a process of informing clientele regarding procedures and strategies utilized during treatment has been included. Additionally, an explanation as to what the client can expect as an outcome or benefit is explained. The client will be provided with the rationale for participation in the service, what the risks are of utilizing and not utilizing the service and what other options are for treatment.

**Appointments:**

Appointments are scheduled for 45 minutes. The therapist will attempt to work around the client’s work and/or school schedule whenever possible. Cancellations should be made 24 hours prior to the appointment time whenever possible. Failure to appropriately cancel appointments will result in a $30 charge to be paid by the responsible party and will not be billed to insurance. Failure to meet the financial obligations may result in services and /or legal action which may include collection agencies. We recognize that it is not always possible to provide notice and will be evaluated by the therapist. Termination of services after three attempts have been made to rectify the situation. Clients are generally seen weekly, unless determined otherwise by the therapist and client. You may discontinue treatment at any time; however, it is beneficial to discuss this decision with your therapist. In the event of an emergency please call 911 or the Crisis Line and notify your therapist after 8:00 a.m. the next day. Your therapist may grant permission to call her/him directly to deal with certain situations.

It is the client’s responsibility to attend scheduled appointments. \_\_\_\_\_\_\_\_\_Initial

**Confidentiality:**

Issues discussed in therapy are important and are generally legally protected as both confidential and “privileged.” However, there are limits to the privilege of confidentiality. These situations include:

1. SUSPECTED ABUSE OR NEGLECT OF A CHILD, ELDERLY PERSON OR A DISABLED PERSON
2. When your psychiatrist or therapist believes that you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires your therapist to inform that person, as well as the legal authorities.
4. If your psychiatrist or therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc.
5. When your insurance company is involved (filing a claim, insurance audits, case review, or appeals, etc.).
6. In the event of natural disasters, whereby protected records may become exposed or if the office is vandalized.
7. When otherwise required you may be asked to sign a release of information so that your therapist may speak with other professionals or to family members. Please note that Community Centered Counseling Services has a contract with your insurance company which requires supplying confidential information such as treatment plans, progress reports, verbal and written monthly updates and discharge summaries to the assigned case manager.
8. When the therapist determines it necessary or beneficial to consult with another professional(s).

I acknowledge understanding of the above guidelines regarding confidentiality.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Record Keeping:**

A clinical chart is maintained describing your treatment and progress in treatment, dates of sessions and notes describing each therapy and/or BHIS session. Your records will not be released without your written consent, unless in those situations as outlined in the **Confidentiality** section of this form.

**Insurance:**

I agree to keep the therapist informed of any changes to my health insurance coverage, including dates of termination or changes to my coverage. I understand that termination of coverage will result in the non-payment of services provided to me after that date.

*\* Please read and sign below after all your questions are addressed \**

**I acknowledge that** I have read a copy of my patient rights and responsibilities and accept, understand and agree to abide by the contents of this agreement. I understand that I may withdraw from treatment at any time, but agree to discuss my decision with my therapist.

Name of client (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist/witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_



**Client Rights and Responsibilities**

* Clients have the right to be treated with personal dignity and respect.
* Clients have the right to services that are provided with consideration and respect regarding that person’s

personal values and belief system.

* Clients have the right to privacy and confidentiality of information.
* Clients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation,

ethnicity, age, or disability.

* Clients have the right to participate in an informed way in the decision making process regarding their

treatment planning.

* Clients have the right to discuss with their providers the medically necessary treatment options for their

condition regardless of cost or benefit coverage.

* Clients have the right of member’s families to participate in treatment planning as well as the right of

members over 12 years of age to participate in such planning.

* Clients have the right to individualized treatment, including:
* Adequate and humane services regardless of the source(s) of financial support.
* Provision of services within the least restrictive environment possible.
* An Individualized treatment plan.
* Periodic review of the treatment plan.
* Competent, qualified, and experienced clinical staff to carry out treatment.

Clients have the right to participate in the consideration of ethical issues that arise in the provision of care

services including resolving conflict and participating in investigational studies or clinical trials.

* Clients have the right to designate a surrogate decision-maker if the member is incapable of understanding

a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.

* Clients and their families have the right to be informed of their rights in a language they understand.
* Clients have the responsibility to keep scheduled appointments or to cancel with 24 hour notice whenever

possible.

* Clients will accept termination of services if more than three sessions are missed without prior notice

and/or acceptable explanation.

* Clients have the responsibility to give their provider information needed in order to receive care.
* Clients have the responsibility to follow their agreed upon treatment plan or to communicate their change

of opinion to their provider.

* Clients have the responsibility to participate (to the best of their ability) in their sessions.
* Clients have the right to subpoena their therapist and request documentation for court.

**\*\*\*** The utilization of therapy is not intended for extraction of information for custody or other legal issues, rather for the healthy development and self-actualization of the client. Please be advised, in the event that a therapist is subpoenaed to testify for legal proceedings, there will be a charge for the therapist’s preparation and time determined at the therapist’s discretion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Therapist/Witness Signature



**CLIENT GRIEVANCE AND APPEALS POLICY**

We make every reasonable effort to satisfy all client’s questions or concerns. However, situations may arise in which a client has a grievance. The following steps will be followed when a client voices a concern or files a grievance.

1. Since most concerns are minor or the result of a misunderstanding, the first recourse is to allow the parties directly affected by the client and the therapist) to resolve the matter. This takes place within five working days of the therapist’s knowledge of the clients’ concerns.
2. If the first recourse fails to resolve the clients’ concern, a meeting with the therapist, the client and a third party will be arranged. The third party could be a colleague or other person acceptable to the client. The client with the grievance will be asked as to preference about a third party and every effort will be made to honor any specific request for that third party. This meeting will take place within five working days of the first meeting.
3. If the client’s concern is not resolved by the second step, the therapist will contact the referring provider for consultation and/or further instruction. If, after this consultation, a third meeting seems helpful, one will be scheduled with the client within five working days. If this third meeting fails to result in a resolution, the client will be provided with contact information 9if needed0 to the referring provider in order to make a formal complaint and to obtain a referral to another therapist. The treating therapist will make every reasonable effort to assist the client in this process.
4. Each client grievance will be documented on a grievance form. Detailed written notes will be taken at any and all meetings.

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Printed name of patient (or personal representative and his or her relationship to patient)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or personal representative)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Date



**CONSENT TO TREATMENT and CONSENT TO ADMINISTER**

**CONSUMER HEALTH INVENTORY**

Name of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_years old Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provision of any supporting court documents regarding legal guardianship is required.

Please check one:

\_\_\_\_\_ I have full legal authority to consent to treatment of the minor without obtaining consent or approval from another person.

\_\_\_\_\_ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I hereby authorize Community Centered Counseling Services to provide counseling to the minor in connection with substance abuse, mental health and/or other personal areas of concern.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of legal guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date



**HIPAA PRIVACY RELEASE OF AUTHORIZATION FORM**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the undersigned, hereby authorize and request that Community Centered Counseling Services (CCCS)

\_\_\_\_\_\_ Release to \_\_\_\_\_\_Secure from

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of person or Institution)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Address)

The following information may be included:

\_\_\_\_\_Medical Evaluation or treatment reports

\_\_\_\_\_Psychiatric: Evaluation reports, Clinical notes, discharge summary

\_\_\_\_\_Psychological: Evaluation reports, test results, psychotherapy progress notes

\_\_\_\_\_Substance and alcohol abuse information

\_\_\_\_\_HIV/AIDS-related information

Other information as indicated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the information is to be used for the following purposes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization for release of information covers the period of care for services from:

\_\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_ to \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_ unless revoked by client.

I understand that I may revoke this authorization by sending a written notice to CCCS at 2711 West 63rd street Davenport, Iowa 52806. The revocation becomes effective when it is received. I understand that any information released prior to revocation and which was released because of this authorization will not constitute a breach of confidentiality. Also, the revocation will not be effective if the authorization was obtained as a condition for reviving insurance coverage for services, and the insurer has legal right to contest the claim.

I further have the right to inspect the information disclosed. I understand that Iowa law prohibits disclosure of 3rd party disclosure. I know I am entitled to receive a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or legal guardian Relationship to client Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Warning: The confidentiality of this information is protected by federal laws including the Health Insurance Portability and Accountability Act of 1996 and the Code of Federal Regulations (42CFR Part2 Public Law 93-282, Section 2:31(a) and 2:33) as well as the Iowa law (Iowa code Chapter 28). Iowa law requires that disclosures can only be made pursuant to the written authorization of the patient or the patient’s legal representative. Civil and or criminal penalties may apply to the unauthorized disclosures of mental health information.



Date:

Dear Dr.

I would like to take this opportunity to inform you that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has recently become a patient of our practice. The diagnosis for this client is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. 

The mission of Community Centered Counseling Services is to provide superior client-centered professional counseling, therapy and behavioral health services to empower children, adults, couples and families toward achieving healthy and long-lasting life changes.

When necessary and to provide the highest quality of service, I will inform you of any ongoing issues or treatment and I hope you will reciprocate in kind. Should you have any questions or concerns, please do not hesitate to contact me. The patient and/or patient’s parent/guardian has signed a current release of information which can be faxed to you as needed.

Sincerely,