CLIENT INFORMATION

Date: _____

Name of Client: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

How did you hear about A New Beginning Wellness Center? _____

How would you like to receive reminder alerts for upcoming appointments? Text____ Email____

Translator Needed? Yes ____ No_____

Primary Care Physician: _____ Phone: _____

Would you like counselor to contact primary care physician? Yes ___ No ____

If yes, please fill out the Release of Information form with your physician's information.

Emergency Contact: _____ Phone: _____

Relationship to Client: _____

INSURANCE

Type: Medicaid _____ Private Pay____ Private Insurance_____ Other _____

Insurance Name: _____ Subscriber/Medicaid #: _____

Secondary Insurance: _____ Subscriber #_____

Appointment Cancellation Policy

ALL APPOINTMENTS MUST BE CANCELED 24 HOURS PRIOR TO THE APPOINTMENT WITH THE EXCEPTION OF MEDICAID OR YOU WILL BE BILLED. ARRANGEMENTS CAN BE MADE IN CASE OF EMERGENCIES OR OTHER CIRCUMSTANCES.

Signature Date

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

IDENTIFYING INFORMATION Date of Assessment: _____

Name of Client: _____ Sex (M) _____ (F) _____

Date of Birth _____ Place of Birth _____ Age _____

Religion (optional) _____ Occupation/grade level_____

Additional pertinent information (religious practice, cultural issues, or gender identity)

_____

_____

_____

Employer/School: _____

CHIEF COMPLAINT:

What brings you to therapy at this time?

_____

_____

_____

_____

_____

Presenting Problems (check all that apply)

Symptom	Severity	How long? (days,weeks,months,years)
___ Very unhappy	Mild – Moderate – Severe	
___ Impulsive	Mild – Moderate – Severe	
___ Fire setting	Mild – Moderate – Severe	
___ Irritable	Mild – Moderate – Severe	
___ Stubborn	Mild – Moderate – Severe	
___ Stealing	Mild – Moderate – Severe	
___ Temper outbursts	Mild – Moderate – Severe	
___ Disobedient	Mild – Moderate – Severe	
___ Lying	Mild – Moderate – Severe	
___ Withdrawn	Mild – Moderate – Severe	
___ Infantile	Mild – Moderate – Severe	
___ Sexual Trouble	Mild – Moderate – Severe	
___ Daydreaming	Mild – Moderate – Severe	
___ Mean to others	Mild – Moderate – Severe	
___ Phobic	Mild – Moderate – Severe	
___ Fearful	Mild – Moderate – Severe	

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

___ Destructive	Mild – Moderate – Severe
___ Truancy	Mild – Moderate – Severe
___ Clumsy	Mild – Moderate – Severe
___ Trouble with the law	Mild – Moderate – Severe
___ Bed wetting	Mild – Moderate – Severe
___ Overactive	Mild – Moderate – Severe
___ Running away	Mild – Moderate – Severe
___ Soiled pants	Mild – Moderate – Severe
___ Slow	Mild – Moderate – Severe
___ Self mutilating	Mild – Moderate – Severe
___ Eating Problems	Mild – Moderate – Severe
___ Short attention span	Mild – Moderate – Severe
___ Head banging	Mild – Moderate – Severe
___ Trouble sleeping	Mild – Moderate – Severe
___ Distractible	Mild – Moderate – Severe
___ Rocking	Mild – Moderate – Severe
___ Sickly	Mild – Moderate – Severe
___ Lacks initiative	Mild – Moderate – Severe
___ Shy	Mild – Moderate – Severe
___ Drug use	Mild – Moderate – Severe
___ Undependable	Mild – Moderate – Severe
___ Strange behavior	Mild – Moderate – Severe
___ Alcohol use	Mild – Moderate – Severe
___ Peer conflict	Mild – Moderate – Severe
___ Strange thoughts	Mild – Moderate – Severe
___ Suicide talk	Mild – Moderate – Severe
___ School Performance	Mild – Moderate – Severe
___ Other (please describe below)	Mild – Moderate – Severe

_____

What are your expectations of your child?

_____

_____

_____

What changes would you like to see in your child?

_____

_____

_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

What changes would you like to see in yourself as a parent?

_____

_____

_____

What changes would you like to see in your family?

_____

_____

_____

SOCIAL HISTORY

CURRENT FAMILY SITUATION:

Mother

Relationship to child: _____ biological parent _____ step-parent _____ adoptive parent _____ other

Occupation _____ Education _____

Religion _____ Birthplace _____

Birth date _____ Age _____

Father

Relationship to child: _____ biological parent _____ step-parent _____ adoptive parent _____ other

Occupation _____ Education _____

Religion _____ Birthplace _____

Birth date _____ Age _____

Marital History of Parents:

Biological Parents: _____ married when _____

_____ separated when _____

_____ divorced when _____

_____ deceased Mother or Father _____

Step-parents _____ married when _____

Foster or _____ married when _____

Adoptive parents _____ separated when _____

_____ divorced when _____

_____ deceased Mother or Father _____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Foster/Adoptive Children

Age when child was first placed in the home: _____

Date of adoption finalization: _____

Describe circumstances: _____

_____

_____

What does the child know about his/her birth parents, and birth history? _____

_____

_____

CURRENT LIVING ARRANGEMENTS:

_____ Renting _____ Own _____ Other: _____

_____ House _____ Apartment _____ Other: _____

Number of moves in child's life? _____

Does the child share a room with anyone else? _____ Yes _____ No

If yes, with whom? _____

If no, how long has he/she had own room? _____

Was the child ever placed, boarded, or lived away from the family? _____ Yes _____ No

Explain: _____

OTHERS LIVING IN THE HOME:

Name	Age	Sex	School/Occupation/Grade	Relationship to client

Does the child have any other siblings (biological, step, foster, adoptive) that do NOT live in the home?

_____

_____

BEHAVIORAL HEALTH HISTORY

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Has your child ever been diagnosed with a Mental Health Disorder? If so, please list the diagnoses, when and where and by whom the diagnoses was made.

_____
_____
_____

Has your child had any behavioral health services in the past? If so, please list they type of service (counseling, CBRS, case management, etc…), when, where, and by whom was this service provided.

_____
_____
_____

Please describe any family history of behavioral health diagnoses and/or treatments. Please include how they are related to your child, what they are/were diagnosed with, and what treatments were attempted.

_____
_____
_____

SUBSTANCE USE/ABUSE HISTORY

Does your child currently use illicit substances? If so, please indicate drug(s) of choice, date and quantity of last use. _____
_____
_____
_____

Has your child used any illicit substances in the past? Please describe this, along with any treatment received.

_____
_____
_____

Please describe any past or current nicotine/tobacco use. Include quantity and date of last use. _____
_____

Please describe the child's family history of substance use, including how they are related and any treatment received.

_____
_____
_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

ABUSE/TRAUMA HISTORY

Has your child experienced any type of abuse or trauma during their lifetime? (include physical/emotional/ sexual abuse, neglect, foster care or adoption experiences, death of close relationship, accidents, significant medical experiences, etc..)

_____
_____
_____
_____
_____
_____

EDUCATIONAL HISTORY

Name of School	City/State	Dates: from to	Grade completed at this school
Preschool _____	_____	_____ - _____	_____
Elementary_____	_____	_____ - _____	_____
Junior High _____	_____	_____ - _____	_____
High School _____	_____	_____ - _____	_____

Types of classes: _____ general education _____ resource _____ extended resource
_____ Learning disability _____Emotionally disturbed

Is your child on an IEP or 504 plan? _____ Yes _____ No
If yes, _____ Learning disability_____ Emotionally disturbed

Has child had special testing in school? ____ yes ____ no
Psychological: ___ yes ____ no Vocational: ___ yes ____ no
If yes, please describe results: _____

Has your child skilled any grade levels? _____ Yes _____ No
Has your child been held back or repeated a grade level? _____ Yes _____ No
If yes to either, when and how many years/which grade? _____

Functional grade level at present time? _____

Does child attend school on a regular basis? _____ Yes _____ No

Does child appear to be motivated for school? _____ Yes _____ No

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Has child ever been suspended or expelled? _____ Yes _____ No
Explain: _____
_____

Highest grade on last report card? _____
Lowest grade on last report card? _____
Favorite subject? _____
Least favorite subject? _____

Does child participate in extracurricular activities? ____ Yes ____ No (explain)_____
_____

In school, how many friends does child have: _____ a lot _____ a few _____ none

What are child's educational aspirations?
_____ quit school
_____ graduate from high school
_____ go to college
_____ other: _____

Does or did any member of the child's biologically related family have any difficulties with:
_____ Reading _____ Spelling _____ Math _____ Speech
If yes, please explain: _____
Do you have any concerns about your child's education? _____ Academically _____ Socially
If yes, please explain: _____

VOCATIONAL HISTORY

Current/Past employment:
Job: _____ Employer:_____ How long: _____
Job: _____ Employer:_____ How long: _____
Do you have any concerns about your child's employment history or potential? _____

LEGAL HISTORY

Has your child ever had difficulty with the police? ____ Yes ____ No
If yes, please explain: _____
Has your child ever appeared in juvenile court? ____ Yes ____No
If yes, please explain: _____
Has your child ever been on probation? ____ Yes ____No

Date:	Reason:	Probation Officer (Name & Phone Number):
_____ to _____	_____	_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

MEDICAL HISTORY

CURRENT PRIMARY CARE PHYSICIAN:

Name: _____ Address: _____ Phone: _____ OK to contact? Yes / No

CHILD HEALTH INFORMATION:

Check all health problems the child has had or has now.

	AGE		AGE
_____ High fever	_____	_____ Dental Problems	_____
_____ Pneumonia	_____	_____ Weight Problems	_____
_____ Flu	_____	_____ Allergies	_____
_____ Encephalitis	_____	_____ Skin Problems	_____
_____ Meningitis	_____	_____ Asthma	_____
_____ Convulsions	_____	_____ Headaches	_____
_____ Unconsciousness	_____	_____ Stomach problems	_____
_____ Head injury	_____	_____ Anemia	_____
_____ Concussions	_____	_____ Accident prone	_____
_____ Fainting	_____	_____ High or Low Blood Pres.	_____
_____ Dizziness	_____	_____ Sinus Problems	_____
_____ Tonsils out	_____	_____ Heart Problems	_____
_____ Vision Problems	_____	_____ Hyperactivity	_____
_____ Hearing Problems	_____	_____ Earaches	_____
_____Other Illness(s)	_____ Please describe: _____		

Has child ever been hospitalized? _____ Yes _____ No (If Yes, please explain)

Age How Long Reason

_____ _____ _____

_____ _____ _____

Has your child ever been seen by a medical specialist? _____ Yes _____ No (If Yes, please explain)

Age How Long Reason

_____ _____ _____

_____ _____ _____

Does your child have any drug and/or food allergies? _____ Yes _____ No

If yes, please explain:

_____

_____

_____

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Has your child ever taken, or is he/she currently taking any prescribed medications? _____ Yes _____ No

Age	Medication	Dosage	How Long	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HEALTH OF FAMILY MEMBERS: (excluding patient)
Are there any biologically related family members diagnosed with major illnesses?

Name	Relationship To child	Type of Illness	When Diagnosed	Length of Illness
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is there any history in the child's family of:
_____ Intellectual Disability _____ Epilepsy _____ Birth Defects _____ Schizophrenia
If yes, please explain: _____

DEVELOPMENTAL HISTORY:
PRENATAL
Was your child planned for? _____ Yes _____ No
Normal pregnancy? _____ Yes _____ No

If mother was ill or upset during pregnancy, please explain: _____
_____
Length of pregnancy: _____
Did mother have support during pregnancy? _____
_____

BIRTH
Length of active labor: _____ hrs. _____ Easy _____ Difficult
Full Term: _____ Yes _____ No
If premature, how early: _____
If overdue, how late: _____

Birth Weight: _____ lbs. _____ oz.
Type of delivery: _____ spontaneous _____ cesarean _____ with instruments
_____ head first _____ breech

Was it necessary to give the infant oxygen? _____ Yes _____ No If yes, how long? _____
Did infant require blood transfusion? _____ Yes _____ No

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

Did infant require X-ray? _____ Yes _____ No
Did infant experience anorexia, trauma, or other complications at birth? _____ Yes _____ No
If Yes, please explain: _____
_____

Did mother abuse alcohol/drugs/tobacco during pregnancy? _____ Yes _____ No

NEWBORN PERIOD:

Check all that apply	How long	Severity_____
_____ Irritability	_____	_____
_____ Vomiting	_____	_____
_____ Difficulty breathing	_____	_____
_____ Difficulty sleeping	_____	_____
_____ Convulsions/twitching	_____	_____
_____ Colic	_____	_____
_____ Normal weight gain	_____	_____
_____ Breast fed	_____	_____

DEVELOPMENTAL MILESTONES:
Age at which child:
Sat up: _____
Crawled: _____
Walked: _____
Single words: _____
Full sentences: _____
Bladder trained: _____
Bowel trained: _____
Weaned: _____

Describe the manner in which toilet training was accomplished: _____
_____
_____

SOCIAL DEVELOPMENT:
Relationship to siblings and peers:

_____ Individual play _____ Group play
_____ Competitive _____ Cooperative
_____ Leadership role _____ A Follower

Special habits, fears, or idiosyncrasies of the child:
_____
_____
_____

Special interests, hobbies, skills of the child:

A NEW BEGINNING
Wellness Center

CHILD/ADOLESCENT CLINICAL QUESTIONNAIRE

_____
_____
_____

Please list any other information about your child that would be beneficial for the counselor to know:

_____
_____
_____

_____
Parent/Guardian Signature Date

_____
Therapist Signature/Credentials Date

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Wellness Center

DEPRESSION SCREENING

IN THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS?	NOT AT ALL	SOME DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
FEELING DOWN, DEPRESSED, OR HOPELESS	0	1	2	3
TROUBLE FALLING ASLEEP, STAYING ASLEEP, OR SLEEPING TOO MUCH	0	1	2	3
FEELING TIRED OR HAVING LITTLE ENERGY	0	1	2	3
POOR APPETITE OR OVEREATING	0	1	2	3
FEELING BAD ABOUT YOURSELF, OR THAT YOU'RE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	0	1	2	3
TROUBLE CONCENTRATING ON THINGS SUCH AS READING THE NEWSPAPER OR WATCHING TV	0	1	2	3
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED OR BEING SO RESTLESS OR FIDGETY THAT YOU HAVE BEEN MOVING AROUND MORE THAN USUAL	0	1	2	3
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR HURTING YOURSELF IN SOME WAY	0	1	2	3

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Wellness Center

POLICIES, RIGHTS, & RESPONSIBILITIES

OFFICE POLICY STATEMENT

Please read this office policy statement. Feel free to ask your counselor any questions concerning these policies. You may request a copy for your records.

What to expect from counseling/therapy: Counseling is an individually tailored process which is designed to assist you in dealing with your concerns, coming to a greater understanding of yourself, and using effective means of coping which utilizes personal and interpersonal resources. The counseling/therapy relationship usually involves sharing personal information with your clinician which may at times be sensitive, very private, and even distressing. Therefore it is not uncommon during the course of services to feel somewhat more anxious or upset for a time. If you should feel this way, it is important to share this information with your clinician. While the outcome of counseling is most often positive, the degree to which any particular individual will reach t heir goals or achieve the desired level of satisfaction is not predictable. We work with you to develop an individualized treatment plan outlining your goals and the tasks to achieve those goals. Your participation in this process is vital to achieving these goals. However, all clients have the right to refuse services or any portion of treatment at any time. We will assist you to find another more suitable provider in the community if necessary.

Confidentiality: All information revealed in counseling is confidential with the following exceptions: When a person reveals intent to hurt himself/herself or others and all incidents of neglect, physical and sexual abuse or children and adults. We are required by law to report these causes to the proper authorities. Also, we must submit record if they are subpoenaed through the courts.
We may discuss relevant information with our clinical supervisors, Psychiatrist, Physician or consulting group about your case during supervision. However, be assured that information regarding your care will not be discussed outside those contacts without a HIPAA approved written release of information.

Office Behaviors: Anyone coming in for an appointment that is intoxicated, physically violent or verbally abusive will not be seen. You will however, be billed for your appointment. **Children must, at all times, be supervised by an adult in the waiting room.**

Payment Expectations: You are responsible for timely payment of all services rendered. Payment or co-payment is expected at the time of each visit. A listing of services and fees per clinical hour is provided below. You may be charged for extra time spent on your behalf. This includes appointments that exceed the outpatient psychotherapy session of 20-30 minutes, 45-60 minutes, or 75-90 minutes; printed materials; reports; letters; consultations; travel time for out-of-office services; and telephone calls. A $20.00 charge will be added to your account for any check that does not clear your bank due to insufficient funds.

Private Pay Charges: $80 per session

A NEW BEGINNING
Wellness Center

POLICIES, RIGHTS, & RESPONSIBILITIES

All accounts with a balance after 30 days will accrue interest at the rate of 12.5% per annum. If you are unable to pay for services at the time of each visit, you must sign a written agreement for payment arrangements with the billing office. In the event that you go 30 days without making your prearranged payment, your account may be turned over to our attorney or collection agency for collection proceedings and you will also be responsible to pay the additional collection fees.

Missed Appointments: **A 24-hour advance notice** of any canceled appointment is required. You will be charged for missed appointments.

Medicaid Clients Only: Due to the requirements of Medicaid we cannot bill for missed appointments however, your treatment plan is very important to us and attendance is critical to your success. If you miss an appointment without calling in advance we will give you a courtesy call to see if you need to reschedule. If we are not able to reach you and you have missed more than two consecutive sessions without contacting us or us contacting you then you will receive notification in writing asking if you would like to continue treatment at our location. During this time your clinician may choose to have a welfare check done on you if they feel you may be endangered. If you do not respond within 1 week of receiving our letter indicating you would like to continue your sessions then you will discharged.

Testing: The counselor may request that you participate in a psychological or behavioral test to help determine your treatment plan. Please be aware that all testing of any kind is an additional charge that may or may not be covered by your insurance.

Professional Records: We are required to keep appropriate records. We use Electronic Health Records and paper charts. Because these records may be misinterpreted by a non-clinician, it is our general policy to allow a client desiring to review them only in the presence of their clinician after the matter has been fully discussed and where both agree that such a review would not interfere with services. If we decide that reviewing the record would be emotionally damaging, we would forward a summary to a client's designee.

Legal Proceedings: It is not the general role of a clinician to be involved in court proceedings unless there is agreement at the onset of a professional contract for services. There is a fee A New Beginning Wellness Center charges for clinicians to testify in court. These charges are not covered by insurance. It will be your responsibility to pay the fee and the amount will be discussed at the onset of our contract. This fee is $1500.00 to leave this office and appear in court.
In most judicial proceedings, clients have the right to prevent us from providing any information about them. However, in child custody proceedings, adoption proceedings, and proceedings in which the clients' emotional condition is an important element, a judge may require a clinician's testimony if he/she determines that resolution of the issues before him/her requires it. Testimony may also be ordered in 1) a legal proceeding relating to psychiatric hospitalization; 2) in malpractice and disciplinary proceedings brought against clinician/agency; 3) court-ordered psychological evaluations; and 4) certain legal cases where a client has died.

POLICIES, RIGHTS, & RESPONSIBILITIES

You have the right to:

- Get respectful treatment that will be helpful to you/your child.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist to his/her supervisor, who will take the report seriously and investigate the matter.
- Ask for and get information about the therapist's qualifications, including his/her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapist (in case of vacation and emergencies) and cancellation policies.
- Refuse audio/video recording of the session (but you may ask for it if you wish).
- Refuse to answer any question or give any information you choose not to answer or give.
- Know if your therapist will discuss your case with others (supervisors, consultants or students).
- Ask the therapist to inform you of your progress.
- File a grievance against A New Beginning Wellness Center and/or your therapist within a reasonable period of time from the date of occurrence; be heard by an impartial decision-maker, and the resolution to not exceed 20 working days. Written explanation of the resolution of the grievance will be provided to the client/parent/guardian.
- Have assistance in filling out the grievance, an explanation of the process, an investigation of the grievance on your behalf, a hearing, and a representative for yourself at the hearing if desired by you. Stephanie Pearl, Executive Director, is the Privacy Officer and Client's Rights Officer at A New Beginning Wellness Center. You are encouraged to talk with her about any complaints, problems or grievances. She will make attempts to resolve the grievance to your satisfaction. If the grievance is unable to be resolved informally, she will assist you in filing the grievance. You may contact Stephanie Pearl at A New Beginning Wellness Center for assistance in all parts of the process. If Stephanie Pearl is the subject of the grievance, then the clinical staff person with the most experience will offer assistance.
- Have advocacy services or legal services in the filing of your complaint.
- Initiate a complaint with the Idaho Department of Health and Welfare and/or appropriate professional licensing or regulatory association. A New Beginning Wellness Center's staff will willingly assist you with the address or phone number of any of these agencies.

POLICIES, RIGHTS, & RESPONSIBILITIES

I understand that by signing this document I/we understand and agree to the following:

- I and/or my child will be receiving counseling/psychotherapy services to address the problems I or my child have chosen to address, which will be outlined in a treatment plan. Inherent in this are decisions to change my life or that of my child's life and mental health.
- I and/or my child will be involved in the development of the treatment plan. The goals created will be to promote a happier, healthier life for myself and/or my child.
- There are risks I am willing to take for myself and/or my child. These include, but are not limited to, an initial decline in mental health. I and/or my child's mental health could decline to the need for medication or hospitalization. I or my child could make decisions to change, which may or may not be to me or my child's benefit.
- The choice of provider is mine/my child's and I know that here are other providers I could choose. I understand I can refuse the services offered. I am choosing A New Beginning Wellness Center as my provider of choice.
- Services are provided at a time and location that are convenient, acceptable, and suitable to the client and the provider. The services are to be coordinated, consistent and not a duplication of services.
- Primary financial responsibility is mine. If Medicaid does not pay for services, due to a lapse in coverage due to my oversight, I will be expected to pay for the services provided during the lapsed time.

Signing this document below is an indication that we have had the opportunity to discuss questions or any confusion you might have regarding confidentiality and that you understand the above statements. I have read this statement about confidentiality and I have been given the opportunity to discuss it with my clinician. I understand that I may discuss any concerns or questions regarding confidentiality at any time during our work together. I have read and understand and/or my therapist has explained these rights to me. I can request a copy of them at any time. A copy of this is available in plain sight in the waiting room.

_____

Client/Guardian Signature Date

Consent Form

(Per Federal HIPAA Law Section 164.506)

This is to inform you that your protected health information (PHI) may be used and disclosed to carry out treatment, payment, or health care operations.

You may refer to Federal HIPAA Law #164.520 for more complete description of such uses and disclosures. You have the right to review this notice before signing and giving your consent.

You have the rights to request how your PHI is used or disclosed to carry out treatment, payment, or health care operation. We are not required by law to agree to the requested restrictions, and can refuse service if not signed. If we agree to any restriction they are binding on us. You have the right to revoke this consent in writing.

This form must be signed and dated before services can be given.

_____

Guarantor Date

A NEW BEGINNING
Wellness Center

RELEASE OF INFORMATION

Client Name: _____ **Date of Birth:** _____

I authorize A New Beginning Wellness Center (8660 W Emerald, Ste 142, Boise, Idaho 83704) to exchange confidential information concerning the above-named client with the following:

Agency/Contact: _____

Mailing Address: _____

City/State/Zip: _____

Phone/Fax: _____

I authorize:

___ Informal communication regarding all client information between both parties.

AND/OR

___ Copies of the following documents to be mailed/faxed to the agency listed above

___ Copies of the following documents to be mailed/faxed to A New Beginning Wellness Center

___ Limited verbal communication (no copies) related only to the following records:

(Check which documents are authorized to be released)

___ Bio-Psychosocial Evaluation	___ Psychiatric Evaluation	___ Report Cards/Transcripts
___ Licensed Evaluation	___ Medication Management	___ Behavioral Program
___ Treatment Plan/Reviews	___Medical History & Physical	___Individual Education Plan
___ Progress Summary	___ Immunization Record	___Other: _____
___Discharge Review	___ Lab Results	___Other: _____

Purpose of Release:

___ Assessment ___ Treatment Coordination ___ Other: _____

___ Notification of compliance with court-ordered treatment (e.g. DHW, DJC, Probation)

- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from A New Beginning Wellness Center.
- I understand that if I am court-ordered into treatment and refuse to allow A New Beginning Wellness Center to share information with those responsible for monitoring my compliance with mandated treatment, this may result in negative consequences imposed by the court.
- I understand that I may revoke this authorization in writing at any time; however, I cannot revoke authorization for action that has already been taken.
- A copy of this release shall be as valid as the original.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED

_____ _____

Client/Legal Guardian Signature Date