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 #: __________________________

Name of Policy Holder: ___________________________ Date of Birth: __________________________________

Address of Policy Holder: ____

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

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ADULT CLINICAL QUESTIONNAIRE

IDENTIFYING INFORMATION Date of Assessment: ______________________

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

Date of Birth ____________________ Place of Birth _________________________________ Age _______________

Religion (optional) ______________________________ Occupation ____

Employer: ____

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

____

____

____

CHIEF COMPLAINT:

What brings you to therapy at this time?

____

____

____

____

____

Presenting Problems (check all that apply)

Symptom	Severity	How long? (days,weeks,months,years)
____ Difficulty falling asleep	Mild – Moderate – Severe	
____ Difficulty staying asleep	Mild – Moderate – Severe	
____ Insomnia for 2+ days	Mild – Moderate – Severe	
____ Sleeping too much	Mild – Moderate – Severe	
____ Sudden mood swings	Mild – Moderate – Severe	
____ Irritability	Mild – Moderate – Severe	
____ Aggression/angry outbursts	Mild – Moderate – Severe	
____ Spend money impulsively	Mild – Moderate – Severe	
____ Promiscuous behavior	Mild – Moderate – Severe	
____ Feeling of grandiosity	Mild – Moderate – Severe	
____ Extreme sadness	Mild – Moderate – Severe	
____ Withdrawn/avoid others	Mild – Moderate – Severe	

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ADULT CLINICAL QUESTIONNAIRE

____ Increased appetite Mild – Moderate – Severe ____________________
____ Decreased appetite Mild – Moderate – Severe ____________________
____ Experience fatigue Mild – Moderate – Severe ____________________
____ Feel overly emotional Mild – Moderate – Severe ____________________
____ Suicidal thoughts Mild – Moderate – Severe ____________________
____ Low self-esteem Mild – Moderate – Severe ____________________
____ Feelings of depression Mild – Moderate – Severe ____________________
____ Using alcohol or drugs Mild – Moderate – Severe ____________________
____ Experience nightmares Mild – Moderate – Severe ____________________
____ Experience flashbacks Mild – Moderate – Severe ____________________
____ Feelings of hopelessness Mild – Moderate – Severe ____________________
____ Feelings of worthlessness Mild – Moderate – Severe ____________________
____ Lack of motivation Mild – Moderate – Severe ____________________
____ Difficulty making decisions Mild – Moderate – Severe ____________________
____ Hearing voices Mild – Moderate – Severe ____________________
____ Hallucinations Mild – Moderate – Severe ____________________
____ Paranoia Mild – Moderate – Severe ____________________
____ Heart racing/pounding Mild – Moderate – Severe ____________________
____ Difficulty breathing Mild – Moderate – Severe ____________________
____ Pressure/heaviness in chest Mild – Moderate – Severe ____________________
____ Dizziness Mild – Moderate – Severe ____________________
____ Feeling disconnected Mild – Moderate – Severe ____________________
____ "Spacing out"/losing time Mild – Moderate – Severe ____________________
____ Feeling apart from your body Mild – Moderate – Severe ____________________
____ Fear of dying Mild – Moderate – Severe ____________________
____ Chills/hot flashes Mild – Moderate – Severe ____________________
____ Trembling/shaking Mild – Moderate – Severe ____________________
____ Feeling numb Mild – Moderate – Severe ____________________
____ Difficulty focusing Mild – Moderate – Severe ____________________
____ Difficulty staying on task Mild – Moderate – Severe ____________________
____ Difficulty concentrating Mild – Moderate – Severe ____________________

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ADULT CLINICAL QUESTIONNAIRE

____ Difficulty with relationships Mild – Moderate – Severe ______________________
____ Work performance difficulty Mild – Moderate – Severe ______________________
____ Other (please describe below) Mild – Moderate – Severe ______________________

What would you like to get out of counseling?______________________________

What changes would you like to see in yourself? ______________________________

COUNSELING HISTORY

Agency/Counselor Name: ______________________________

Address/Phone Number: ______________________________

OK to contact? ____ Yes ____ No (Please sign release of information if OK to contact)

Reason for counseling: ______________________________

How long did you attend? ______________________________

Did you find counseling to be a positive experience? Was it beneficial? (Please explain): ______________

PSYCHIATRIC HISTORY

Have you had psychiatric testing? If so, where/when. ______________________________

Please list any past psychiatric diagnoses: ______________________________

Past psychiatric hospitalizations: ______________________________

Past suicide attempts: ______________________________

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ADULT CLINICAL QUESTIONNAIRE

Do you have access to excessive amounts of medications? ____ Yes ____ No (Please explain)________________

____

Do you have access to weapons? ____ Yes ____ No (Please explain) ____________________________________

____

Are there any other safety concerns? ____Yes ____ No (Please explain)____________________________________

____

Please list anyone in your family who has psychiatric concerns and/or diagnoses, including suicide attempts or completion. ____

____

____

____

Please list anyone in your family who has been hospitalized for mental illness. ______________________________

____

ABUSE & TRAUMA HISTORY

Please list any history of physical, sexual, or emotional abuse?____

____

____

____

____

Please list any history of traumatic experiences? (Including but not limited to; abusive childhood, foster care or adoption experiences, death of close relationship, accidents, significant medical experiences, etc.)__________

____

____

____

Please list any <u>family</u> history of abuse/trauma? ____

____

____

____

DRUG AND ALCOHOL HISTORY

Please list any current drug/alcohol Intake (please list which drugs or alcohol; frequency; how much): ________

____

____

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ADULT CLINICAL QUESTIONNAIRE

Please list any past drug/alcohol intake (please list last use): ______________________________

____

____

Please list any outpatient or inpatient drug/alcohol treatment that you have had: ______________________________

____

____

____

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

____

Is there a family history of substance abuse? (Please explain) ______________________________

____

____

MEDICAL HISTORY

Current primary care physician:

Name:	Address:	Phone:	OK to contact?
______________	______________________	____________	Yes / No

Please list any previous or current significant health problems. ______________________________

____

____

____

Have you seen a medical specialist regarding these or other problems? (Please describe) ______________

____

____

Have you ever been hospitalized for a significant health problem? (Please describe) ______________

____

____

Do you have any food and/or drug allergies? (Please describe) ______________________________

____

Please list any family members who have significant illnesses. ______________________________

____

____

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ADULT CLINICAL QUESTIONNAIRE

MEDICATION HISTORY

Please list both past and current medications. Use back of page if more space is needed.

Medication	Dosage	Reason	Prescribing Doctor	Dates Taken

LEGAL HISTORY

Please list any past and/or current involvement with law enforcement. ______________________________

SOCIAL HISTORY

Please describe your current family situation. ______________________________

Please describe any concerns you have with the quality of your relationships, including family, friends, and romantic partners. ______________________________

Others living in the home:

Name	Age	Sex	School/Occupation/Grade	Relationship to client

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ADULT CLINICAL QUESTIONNAIRE

EDUCATIONAL & OCCUPATIONAL HISTORY

Please check highest grade completed. ____ Elementary ____ High School ____ Some college

____ College graduate ____ Professional Degree: ____

Please check which best describes your overall experience with your education:

____ Dissatisfied ____ Satisfied ____ Good ____ Bad ____ N/A

Please list current occupation. ____

Are you satisfied with your current position? ____

Do you have concerns that are related to your education or occupation? (Please explain) ____________

____

____

____

Parent/Guardian Signature Date

____

Therapist Signature/Credentials Date

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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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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. **<u>Children must, at all times, be supervised by an adult in the waiting room.</u>**

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

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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.

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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.

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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

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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

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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

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