***Counseling Treatment Outreach***

**1395 Mustang Rd.**

 **Helena, MT 59602**

**Phone: (406)475-2857**

The purpose of this questionnaire is to obtain a comprehensive picture of you or your child’s mental health background. In treatment, records are necessary to provide high quality services. By completing these questions, as fully and accurately as possible, it will help to ensure the highest quality of care. All case records are kept confidential – **No one outside of this clinic will be permitted to see these records without your written permission.** If you do not desire to answer a particular question, please just state “Do Not Care to Answer”. If not applicable, please state N/A.

**\*PLEASE PRINT AND USE A PEN**

**\*\* THESE FORMS MUST BE FILLED OUT COMPLETELY PRIOR TO THE FIRST APPOINTMENT.**

|  |  |
| --- | --- |
| Patient Name: | Date: |
| Preferred name/nickname: | Email Address: |
| Address: |
| City: | State: | Zip Code: |
| Date of Birth: | S.S. #: |
| Phone (cell): | Phone (home): |
| Phone (work): | Phone (other): |
| Gender: Male Female | Favorite Candy Bar: |
| Marital Status: Single Married Cohabitating Separated Divorced Widowed |
| Occupation: | Employer: |
| **Emergency Contact:** | Phone: |
| **FOR CHILD CLIENTS ONLY:** |
| Primary Guardian:  Relationship to client: |
| Phone: | Address: |

**Presenting Problem**

|  |
| --- |
| Reason for seeking therapy: |
| What do you hope to gain from therapy: |

**INFORMED CONSENT**

I have received a copy and read the HIPPA Privacy Policy for Counseling Treatment Outreach.

I have received a copy of, understand, & I agree to Counseling Treatment Outreach’s Service Agreement.

I consent to have my insurance company billed for the services provided by Counseling Treatment Outreach.

I consent to psychotherapy treatment by Counseling Treatment Outreach.

If my account is not paid, and therefore turned into collections, I will be responsible for all collection costs, court costs and attorney fees.

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Clients Name Date

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

Client’s (or Responsible Party’s Signature Relationship to Client Date

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| --- |
| **RESPONSIBLE PARTY FOR AUTHORIZATION OF MEDICAL TREATMENT** |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: M F Age \_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_ Single Married Widowed Divorced Separated

Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PRIMARY INSURANCE** |

Insured Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sex: M F Age \_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_ Single Married Widowed Divorced Separated

Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **ADDITIONAL INSURANCE** |

Is patient insured by additional insurance? Yes No

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Sex: M F Age \_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_ Single Married Widowed Divorced Separated

Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_

Please check whether you are covered by the following:

 Yes No

**Medicare**

**Medicaid**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Responsible Party Signature Date

Relationship to Patient

**FINANCIAL POLICY AND CONTRACT FOR SERVICES**

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of our care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

 **Fees & Billing**

* Payment is due in full at the end of each session by cash, check or credit card.
* Rates are subject to change at any time.
* There will be a $25 fee for any canceled check.
* If you are paying out of pocket for services (not billing insurance) you will receive a discount from the standard rates.

**Health Insurance Coverage**

We sill work with your insurance company to pay for your visit. However, all co-pays are due at the end of each session. If your insurance company does not pay for the visit, you will be responsible for the balance of all charges.

**Confidentiality**

* The information you share will be kept confidential. I will ask you to sign a release-of0information form before discussing your treatment, or sending records about you to anyone else.
* Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances.

The limits of confidentiality are:

1. **If you were sent to me by court or an employer** for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with me telling.
2. If you are **involved in a law suit,** and you tell the court that you are in therapy, I may the be ordered to show the court my records. Please consult your attorney about these issues.
3. If you **threaten to harm** yourself or another person, the law requires me to try to protect you and/or that other individual.
4. If I believe a **child, an elderly individual, or a vulnerable adult has been or will be abused or neglected,** I am legally required to report this to the authorities.
5. If I **bill your insurance** it will have a mental health diagnosis listed and it will become part of your permanent medical record.
6. In order to provide you with the best treatment I may **consult with other mental health professionals** about your case.

**Late Cancellation/No Show Policy**

If you are unable to make your scheduled appointment, please **cancel at least 24 hours in advance** so another client can be scheduled during that time. **If 24 hours notice is not given, you will be charged the full session amount**.

**If Case of Emergency**

If you are experiencing an emotional, behavioral, or medical crisis, call 911 or go to the nearest emergency room. We do not provide 24 hour crisis services.

**I understand, and agree to the policies as stated above, and I give consent for treatment by Counseling Treatment Outreach.**

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 Clients Name Date

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

Client’s (or Responsible Party’s) Signature Relationship to Client Date

**Client Rights and Responsibilities Agreement**

As a client of Counseling and Treatment Outreach you have the **right**:

* To be treated with respect, dignity, consideration, and compassion.
* To receive services free of discrimination on the basis of race, color, ethnicity, national
origin, sex, gender identity, sexual orientation, religion, age, class, physical or mental ability.
* To receive information in terms and language that is understandable, and is culturally
appropriate.
* To be informed about services and options available, including the cost.
* To the assurance of confidentiality of all personal information, communication and records.
* To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
* To communicate and visit with family, attorney, clergy, physician, counselor, or case manager, unless therapeutically contraindicated or court restricted.
* To be informed of agency policies and procedures that affect client or guardian’s ability to make informed decisions regarding client care, to include:
1. Program expectations, requirements, mandatory or voluntary aspects of the program
2. Consequences for non-compliance
3. Reasons for involuntary termination from the program and criteria for re-admission
4. Program service fees and billing
5. Safety and characteristics of the physical environment where services will be provided
* To file a grievance about services you are receiving or denial of services.

As a client of Counseling Treatment Outreach, you have the **responsibility**:

* To treat other applicants, clients, volunteers, and staff with respect and courtesy.
* To protect the confidentiality of other clients you encounter.
* To be free of alcohol or mind altering drugs while receiving services.
* To make and keep appointments or to call to cancel or change an appointment time.
* To inform us of changes in your address and phone number.
* To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients,
staff, or volunteers.

I understand the above client rights, understand my responsibilities, and agree to comply with
them. I understand that violation of these responsibilities may result in termination from treatment. I understand the grievance policy referenced. I understand that I may request and receive a copy of this policy at any time.

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Client Signature Date

**NOTICE OF PRIVACY PRACTICE**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  PLEASE REVIEW THIS NOTICE CAREFULLY. Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as “protected health information.”  This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law and the APA Code of Ethics. It also describes your rights regarding how you may gain access to and control your protected health information.

I am required by law to maintain the privacy of protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information.  I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time.  I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy in our office, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**How I May Use And Disclose Health Information About You**

**For Treatment**:  Your protected health information may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services.  This includes consultation with clinical supervisors or other treatment team members.

**For Payment**:  I may use and disclose protected health information so that I can receive payment for the treatment services provided to you.  This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.  If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of protected health information necessary for purposes of collection.

**For Health Care Operations**:  I may use or disclose, as needed, your protected health information in order to support my business activities including, but not limited to, quality assessment activities, employee review activities,, licensing, and conducting or arranging for other business activities.  For example, I may share your protected health information with third parties that perform various business activities (e.g., billing or typing services). This is allowed only if I have a written contract which requires that business to safeguard the privacy of your protected health information.

**Required by Law**:  There are occasions which require me under law to disclose your protected health information with or without your authorization.  Some examples are:

* If you are in imminent danger of committing suicide I am legally and ethically bound to intervene in any way necessary to prevent that, including contacting family members and the police.
* To the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the Federal privacy requirements.
* If you are at risk of being a serious and imminent threat to the health or safety of a person or the public.  I will disclose information to prevent or lessen that serious threat. I will disclose it to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
* If there is suspicion of neglect or abuse of a child in the past, present or future I am required by law to report that to the Idaho Division of Child and Family Services or the police.
* If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Idaho Adult Protective Services or the nearest law enforcement agency as soon as I become aware of the situation.
* Idaho law requires that I report the names of any individuals having communicable diseases to the Health Department.
* I may disclose your personal health information in accordance with workers compensation laws.
* If you become involved in the court system a judge can order that I provide information about you.  Two examples of this are child custody cases and cases in which clients bring action against therapists.

**With Your Verbal Permission**:  I can share some information about you with your family or close others.  I will only share information with those involved in your care and anyone else you choose such as close friends or clergy.  I will ask you about who you want me to tell what information about your condition or treatment. You can tell me what you want and I will honor your wishes as long as it is not against the law.  If it is an emergency – so I cannot ask if you disagree – I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information, in an emergency, I will tell you as soon as I can.  If you don’t approve I will stop, as long as it is not against the law.

**With Your Written Authorization**:  Uses and disclosures not specifically permitted by the circumstances described above will be made only with your written authorization, which may be revoked

**Your Rights Regarding Your Protected Health Information**

You have the following rights regarding protected health information I maintain about you.  To exercise any of these rights, please submit your request in writing to our office.

* **Right of Access to inspect and Copy**.  You have the right, which may be restricted only in exceptional circumstances, to inspect and copy protected health information that may be used to make decisions about your care.  Your right to inspect and copy protected health information will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.  I may charge a reasonable, cost-based fee for copies.
* **Right to Amend**.  If you feel that the protected health information I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
* **Right to an Accounting of Disclosures**.  You have the right to request an accounting of certain of the disclosures that I make of your protected health information.  I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
* **Right to Request Restrictions**.  You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment, or health care operations.  I am not required to agree to your request.
* **Right to Request Confidential Communication**.  You have the right to request that I communicate with you about health matters in a certain way or at a certain location.  For instance, you can ask me to avoid calling you on selected phone numbers or ask that I send bills to an alternate address.
* **Right to a Copy of this Notice**.  You have the right to a copy of this notice.
* **Complaints**: If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our office.