



ABC Therapy LLC

Client Registration Form (Please Fill Out In Black Ink)

Last Name		First Name	Middle Initial	Social Security #
Date of Birth	Age	Home #		Cell #
Address		City	State	Zip Code
Race ☐ Caucasian(White) ☐ African-American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other:				
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:				
Marital Status (Circle One) Single Married Divorced Widowed		Gender (Circle One) Male Female They/Them		Employer/School
Emergency Contact (Other than someone who lives with you)			Relationship To You	Phone #

Responsible Party Information (Spouse or Parent)

Last Name		First Name	Middle Initial	Home #	Work #
Employer	Employers Address			Date of Birth	
Relationship to the Patient		Occupation	Department	Social Security #	

Primary Insurance Information

Insurance Company Name		Claims Mailing	Address	City	State	Zip Code	Phone #
ID #	Group Name and Number		Insured Party			Date of Birth	
Effective Date	Deductible/ Co- Pay Information			Deductible Met?		Relationship To the Patient	

Secondary Insurance Information (If Applicable)

Insurance Company Name		Claims Mailing	Address	City	State	Zip Code	Phone #
ID #	Group Name and Number		Insured Party			Date of Birth	
Effective Date	Deductible / Co-Pay Information			Deductible Met?		Relation To The Patient	

I hereby guarantee payment for the entire balance of the above-named patient. Co-payments and deductibles are due at the time of service. I authorize treatment for the above-named patient. I assign and authorize payment and medical benefits directly to ABC Therapy and/or its representatives. I authorize release of any information, including confidential medical records, requested by insurance companies, payers or government agencies in connection with this assignment. To cancel an appointment, the above-named patient must notify ABC Therapy at least 24 hours prior to the scheduled time, or else I will be responsible for paying a \$30.00 CANCELLATION FEE. I agree to fulfill my financial obligations to the program, including the cost for a collection agency.

I have read and understand, agree to the described disclosure, financial policy, and various releases and guarantees.

Signature of Responsible Party: _____ Date: _____



ABC THERAPY

DEMOGRAPHIC DATA FORM

Patient Name:		Date of Birth:	
Employer:		Property (if casino/union)	
DEMOGRAPHIC DATA			
Gender	Race/Ethnicity	Referral Type	Religion/Spiritual
☐ Male ☐ Female ☐ Transgender ☐ They/Them	☐ Caucasian, Euro-American ☐ African American ☐ Native American ☐ Asian/Pacific Island ☐ Hispanic, Latino-American ☐ Other ☐ Hispanic Or Latino ☐ Not Hispanic or Latino ☐ Other	☐ Self ☐ Insurancee Directory ☐ Manager/Spervisor ☐ Medical ☐ HR/Personnel ☐ Other	☐ Christian ☐ Jewish ☐ Muslim ☐ Catholic ☐ Hindu ☐ Buddhist ☐ Other
Relationship	Education Level		Marital Status
☐ Self ☐ Spouse ☐ Child ☐ Other Dependent ☐ Data Not Available	☐ Not Available ☐ K-12 ☐ Pre-Kindergarten ☐ Some High School ☐ High School GED ☐ Some College ☐ College Graduate ☐ Graduate Degree		☐ Single ☐ Married ☐ Divorced ☐ Widowed
Issues- Check all that apply			
☐ Alcohol ☐ Eating Disorder ☐ Gambling ☐ Illicit Drugs ☐ Prescription Drugs ☐ Anxiety ☐ Anger ☐ Behavioral/Conduct ☐ Depression ☐ Grief/Loss ☐ Learning ADD/ADHD	☐ Post Traumatic Stress Disorder ☐ Sexual Issues ☐ Stress/Burnout ☐ Trauma ☐ Abuse/Neglect ☐ Dependent Care ☐ Family/Child ☐ Martial/ Relationship ☐ Workplace-Peers ☐ Workplace- Supervisor ☐ Financial	☐ Housing ☐ Legal ☐ School/Education ☐ Chronic Pain ☐ Accident/Truama ☐ Death of a Co-Worker ☐ Death in Family- Close Relationship ☐ Fraud ☐ Serious Illness/ Disability Family	



ABC THERAPY

CONSENT FOR SERVICES

____ I volunteer to participate in the ABC Therapy Program.

____ I being the parent/guardian of _____, voluntarily grant consent for the above named person to participate in the ABC Therapy Program.

I grant permission with the understanding/recognition of ABC Therapy as a counseling program whose goal is to facilitate healthy relationships. I accept the responsibility of working toward this goal by participating in any activity that, in the discretion of the clinical team, works towards achieving the objectives put forth.

I understand that I have a right to be informed as to:

- a) The nature and consequences of the recommendation for treatment
- b) The reasonable risks, benefits and purposes of the recommendations for treatment available;
- c) Any alternative recommendation for treatment available to me.

I understand that I may withdraw my consent to any and all parts of the recommendation for treatment and referral, in writing, at any time.

I agree to hold ABC Therapy representatives free from any, liability of any which might occur to the above named minor or myself while on the premises of ABC Therapy. Any activity, injury or damages sustained while participating in any program function of ABC Therapy.

I will accept responsibility for payment of any damages done to the property or persons by the above named while she/he attends ABC Therapy Program.

This permission and agreement in no way implies that power of attorney is granted to ABC Therapy nor does ABC Therapy assume such power of attorney.

Client Signature

Date

ABC Therapy Staff

Date



ABC THERAPY LLC

Consent for an Intern to Diagnose, Evaluate and Treat the Patient

Client's Name: _____ Date of Birth: _____

Interns (Licensed Clinical Counselors)

Prior to becoming licensed as a Licensed Clinical Counselor in the State of Nevada, individuals must complete an internship program in a clinically approved setting.

ABC Therapy is a clinically approved setting, which uses interns to diagnose, evaluate and treat ABC Therapy clients under direct supervision of the approved supervisors.

A supervisor at our facility, approved by the State of Nevada, oversees the work of the interns.

Interns are required to maintain client confidentiality, as required by federal and state law.

Consent

I have read the above information presented by ABC Therapy, hereby I consent to having a certified intern (Licensed Clinical Counselor) conduct an assessment, individual sessions at ABC Therapy under direct supervision of a licensed supervisor.

Signature of the Client (including minors) Date

Signature of the Legal Guardian (if applicable) Date

ABC Therapy Staff Date



ABC Therapy LLC

730 N. Eastern Ave, Las Vegas, NV 89101-2885
702-598-2020 702-598-2018
www.abctherapy.net

TELEHEALTH & TELEMEDICINE CONSENT FORM

DEFINITION OF SERVICES:

I hereby consent to engage in telehealth/telemedicine with ABC Therapy LLC. Telehealth/telemedicine is a form of behavioral health and psychiatric service provided via internet technology, which can include consultation, treatment, and transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth/telemedicine involves the communication of my medical/mental health information, both orally and/or visually. Telehealth/telemedicine has the same purpose or intention as psychotherapy and psychiatric treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth/telemedicine:

CLIENT'S RIGHTS, RISKS, and AND RESPONSIBILITIES: ?

- I, the client/ Patient, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. ?
- I understand the laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with ABC Therapy.
- I understand that there are risks and consequences of participating in telehealth/telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my behavioral health/ medical information could be accessed by unauthorized persons.
- I understand there is a risk that services could be disrupted or distorted by unforeseen technical problems. In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be asked to attend sessions at the agency.
- I understand that I may benefit from telehealth/telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, I understand my condition may not improve, and in some cases may even get worse.
- If I am experiencing a crisis, or if I cannot contact ABC Therapy, In case of an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in Telehealth/telemedicine. I am responsible for providing the necessary computer, tablet or phone and internet access for my telehealth/telemedicine sessions, and for arranging a location with privacy that is free from distractions or intrusions for my session. It is the responsibility of the treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand this consent will be reviewed annually.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION PROVIDED ABOVE REGARDING
TELEHEALTH/TELEMEDICINE AT ABC Therapy LLC.

Signature

Date

Staff Signature

Date

ABC Therapy LLC
REQUEST FOR INFORMATION AND/OR
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Information Requested From: ABC Therapy LLC

Information Released To: _____ I hereby
authorize and/or consent to the disclosure of the information checked below from the records of:

NAME: _____ Date of Birth: _____

Each item or information to be released must be initialed by the client

☐ Discharge Summary ☐ Medical Records ☐ Monthly status reports

☐ Treatment Plans ☐ Intake Evaluation/ Diagnosis ☐ Lab results (UA's)

Other/specify) _____
For the purpose of: _____

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. I may revoke this release in writing at any time and without penalty or denial of services.

This authorization expires:

☐ One single disclosure ☐ 90 days from date signed ☐ 1 year from date signed

Other _____
(Note: if not checked or indicated by client, this will expire in one year from date from last service date)

It is understood that the policy of the ABC Therapy LLC is to release only that information about a client or a former client, which, in the judgment of the staff, is considered essential to the purposes for which authorization is requested. This in no way binds ABC Therapy LLC to open its records for inspection, or to otherwise provide information which may violate the above policy. Medical Records are protected by Federal Regulations, Nevada Statutes and/or Administrative Regulations and any further disclosure is prohibited without the consent of the undersigned. ABC Therapy LLC cannot guarantee that further disclosure will not occur.

- A. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefit or enrollment, payment for or coverage of services, or ability to obtain treatment. B. I understand that I may inspect or copy the information used or disclosed.
- C. I understand that I may revoke this authorization at any time by notifying ABC Therapy LLC in writing, except to the extent that:
1. Action has been taken in reliance on this authorization; or
 2. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- D. I understand that I have a right to request and receive a Notice of Privacy Practices from ABC Therapy LLC.
- E. I understand that in cases of suspected or known child maltreatment that the providers of ABC Therapy LLC Counseling are mandated reporters under Federal and State law and is legally responsible for reporting such information to Child Protective Services. I understand that my alcohol / drug treatment records are protected under the federal regulations
- F. I understand that my alcohol / drug treatment records are protected under the federal regulations Governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C. F. R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

I further release my clinician, the agency and the employees of the ABC Therapy LLC from any liability arising from the release of information to the person/agency designated above.

Date	Signature Client			
Date	Signature	Parent	Guardian	Custodian
Date	Signature of Witness			



ABC THERAPY

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the exchange of information concerning:

Full Name of Client

Date of Birth

Obtained in the course of my diagnosis and treatment from the following person or agency:

ABC Therapy LLC

To : _____ (_____) PH: _____
Full Name Relationship to you

The disclosure of records authorized herein required for the following purposes: So the staff of ABC Therapy may communicate with the above name person or agency.

Such information shall be limited to the following type of information (please be specific of information to be disclose, ex.: to make payments, payment information, attendance, progress or lack thereof, etc.) _____

This consent is subject to revocation by undersigned client at any time except to the extent that action has already been taken and if not earlier revoked, consent shall terminate ninety (90) days after discharge from program, without express revocation shall occur under the following conditions;

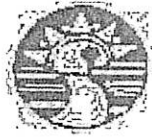
Client Signature

Date

ABC Therapy Staff

Date

CONFIDENTIAL: Violation of this Federal Law and Regulations by program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 and 45 CFR Parts 160, 162, 164 (Federal Regulations and HIPAA).



ABC THERAPY

Financial Responsibility Statement:

Please Initial :

___ Co-payment is expected at the beginning of the session.

___ Not showing up to the appointment or appointments that are canceled with less than a 24 hour notice will be charged a fee of \$30.00

___ There is an \$80.00 fee for completing forms such as disability form, FLMA or ECT.

___ There is a \$0.50 charge per page fee for copying medical records: If your chart is in storage there will be an additional fee of \$15.00, there is no charge to have records sent to another medical provider.

___ Accounts with balances that are past due for more than 90 days from the initial date of service will be forwarded to an outside collection agency. Payments for collection fees, interest fees (small claims court) are the responsibility of the patient/guardian.

All patients pay portions are estimates based on the information provided to ABC Therapy by the patient and his/her/their insurance carrier. The patient/guardian must understand that having an insurance benefit does not guarantee payment. The insurance carrier makes the final decision as to whether payment will be made after it receives and reviews the claim.

When a patient is treated at ABC Therapy as a courtesy ABC staff contacts the patients third-party to check insurance eligibility and pre-certification for insurance payment.

Also as a courtesy, ABC Therapy will be the patient's insurance carrier for all services. The patient/guardian is responsible for all outstanding balances should the insurance company fail to pay all or any part of the charges. The patients Financial Counselor must be informed of all insurance coverage prior to the first visit. Any non-payment as a result of the patients/guardian failure to provide insurance information prior to the first visit is also the patients/guardian financial responsibility.

It is the patients/guardians responsibility to ensure that all insurance premiums, dues, and COBRA payments are current throughout the patient's treatment at ABC Therapy. Any payment denied by the insurance carrier for services provided is the financial responsibility or the patient/guardian.

The patient's insurance coverage is a contract between the patient and the insurance carrier – not between ABC Therapy and the insurance carrier. As such, the patient should be aware that insurance policies often change. As such, it is the patient's sole responsibility to know their coverage. Any cost incurred by the patient/guardian due to a change in the patients insurance policy are also the sole responsibility of the patient/guardian.

Agreement to Provide Complete & Current Information

☐ I agree to notify the agency at the time of future service if there have been any changes in my address, phone number, employment, or primary care physician.

☐ I have provided the name of ALL insurance policies of which I am a member at this time. I acknowledge that to withhold this information is INSURANCE FRAUD.

☐ I acknowledge that to provide information from an insurance that has been terminated prior to the time of receiving services is INSURANCE FRAUD.

By signing below, the patient/guardian acknowledges that they have read, understand and agree to all of the terms of this Financial Responsibility Statement.

Patient Signature (Including Minors)

Date

Legal Guardian Signature (If applicable)

Date

ABC Therapy Staff Signature

Date



ABC THERAPY

CLIENT GRIEVANCE POLICY

Client Name: _____

Date: _____

In the event a client, parents/legal guardians of the client participating in one of ABC Therapy's counseling programs wants to file a complaint, they have the right to do so through the following grievance procedure without fear of discharge or reprisal:

1. **DEFINITION:** Grievance means any written complaint about treatment, including assessment, intervention, and decisions about placement and discharge as well as any complaint concerning staff or operations. Whenever such a complaint is filed, the Executive Director is to be notified via the designated management structure.
2. The grievance procedure is considered part of the treatment process. Every attempt will be made to resolve the grievance.
3. A client filing a grievance may choose other people to accompany him/ her through the Counseling Center's grievance process at his/her own expense.
4. The grievance process includes the following steps:
 - A. The client talks about the complaint with the staff member involved or responsible for the area of concern. Together they are to try to solve the matter informally. The staff member will schedule a meeting with the client within two working days of the grievance being filed and given an opportunity to discuss all concerns.
 - B. If the grievance is not resolved, the client may request a meeting with the Clinical Director and all parties involved in Step A. The Clinical Director will schedule and hold the meeting within five (5) working days of the client's written request.
 - C. If the grievance is still not resolved, the client may request a meeting with the Executive Director and all parties involved in Step B. The Executive Director will schedule and hold the meeting within five (5) working days of the client's written request. The Executive Director's decision is final.
 - D. Any appeal beyond the Center may be referred to the Court or Office that referred you to the agency. This applies only to items and complaints that the agency oversees.
5. In the event a grievance involves a client who is in legal custody of another agency while in treatment, representative(s) of that agency may be involved at any step or all steps.
6. Depending upon the nature and/or severity of the complaint, the Clinical Director may recommend eliminating one or more steps in order to resolve the complaint quickly.

7. Each step of the grievance process must be documented by the staff member hearing the complaint or a designed agency record. A copy will be given to the client.
8. The problem and its resolutions will be documented in writing and included in the client's record.

CLIENT ACKNOWLEDGMENT:

1. I am being provided treatment service at the office marked below:

☐ 730 N. Eastern Ave, Ste 130
Las Vegas, NV 89101
Ph (702) 598-2020

☐ 7 S. Water St, Ste A
Henderson, NV 89015
Ph (702) 568-5971

☐ 1490 W. Sunset Rd. Ste 100
Henderson, NV 89014
Ph (702) 463-9198

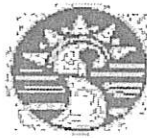
2. I have read, understand and have been provided a copy of the above Grievance Process.

Client Signature

Date

ABC Therapy Staff

Date



ABC THERAPY

Medical Record Retention Policy

MEDICAL RECORD RETENTION POLICY - SB 17 is an act relating to retention and destruction of health care records; provisions in the bill stipulate that the health care records of consumers receiving services must be retained for a period of at least five (5) years, or longer as required by federal law; SAPTA requires six (6) years to be in compliance with HIPAA. The records of consumers under the age of 23 years are prohibited from being destroyed until they reach the age of 23; and, require that certain disclosures regarding the destruction of records be provided to consumers.

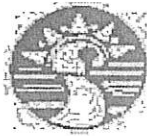
I, _____ acknowledge receiving a copy of the MEDICAL RECORD RETENTION POLICY. In accordance with the provisions of SB17 of the 2009 Session, health care records of a consumer who is less than 23 years of age may not be destroyed. Records may be destroyed if retained for at least 6 years after the person has reached 23 years of age.

Client Signature

Date

ABC Therapy Staff

Date



ABC THERAPY

Acknowledgment Form

Date: _____

I, _____ acknowledge that I have been given a copy of the *Grievance Procedures Policy and Patient's Rights* forms and that they have been fully explained to me.

I have been given a copy to sign of the *Confidentiality* form and the *Authorization to Use Disclose Protected Health Information* form, both were fully explained to me.

I have also been provided with the *Program Orientation Basic* form and it has been fully explained to me.

Client Signature

Date

ABC Therapy Staff

Date

N.A.C. 458.300 (2) (h)

N.A.C. 458.350 (1)

N.A.C. 458.370 (1) (d)

N.A.C. 458.380 (c) (g)



ABC THERAPY

Bill of Rights

To our clients: As recipients of services from ABC Therapy, you are entitled to the following rights:

To receive services without regard to your race, color, religion sex, age, marital status, national origin, veteran status, or disability.

To be treated with respect, consideration, and dignity.

To receive prompt, appropriate treatment and services, in accordance with the laws and standards governing the health care industry.

To inquire and learn about the professional skills and qualifications of those who will provide your services.

To participate in the planning and periodic review of your individual treatment plan.

To be informed of all your rights as our client.

To refuse any treatment.

To be informed about available treatment options and the effectiveness of any such options confidential, to the extent permitted by laws and professional standards.

To receive a copy of your medical records, in accordance with our policies and procedures.

To sign an informed consent if you desire to participate in any clinical or experimental research studies.

To refuse to be filmed or taped.

To receive information about the methods available to file a complaint or grievance regarding our provision of services to you, and know that you will not be retaliated against for filing any such grievance.

To receive a copy of this Bill of Rights at any time requested.

By signing below, I acknowledge that ABC Therapy has provided me with the Bill of Rights written above and that I have reviewed and understand all the terms written above.

Client Signature (Including Minors)

Date

Legal Guardian (If applicable)

Date

ABC Therapy Staff Signature

Date

ABC Therapy LLC

HIPPA OMNIBUS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we ABC Therapy LLC; our business associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing treatment services to you, to pay your treatment bills, to support the operation of the clinical practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a mental health clinician to whom you have been referred, Drug court vendors (drug testers), your medical provider, case managers, etc., to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your services.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes.

We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purpose.

You may revoke the authorization, at any times, in writing, except to the extent that the Drug Court has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information (fees may apply)- Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Your counselor not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications – You have the right to request confidential communication from use by alternative means or at an alternative location.

You have the right to request an amendment to protected health information – if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an account of certain disclosures – You have the right to receive an account of disclosures, paper or electronic, except for disclosures - pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPPA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPPA COMPLIANCE OFFICER: (JULIO C. LANDERO, PhD, MSW, LCADC)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to the form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Please sign below. Please note that by signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Name

Date



Daily Treatment Log

[illegible]



Relationship to client:

- Page 1



Quality of Life Scale (QOL)

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or not satisfied with not doing the activity or having the relationship.

Name:		Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Date:								
1	Material comforts, home, food, conveniences, financial security	7	6	5	4	3	2	1
2	Health – being physical fit and vigorous	7	6	5	4	3	2	1
3	Relationships with parents , siblings, & other relatives – communicating, visiting, helping	7	6	5	4	3	2	1
4	Having and rearing children	7	6	5	4	3	2	1
5	Close relationships with spouse or significant other	7	6	5	4	3	2	1
6	Close friends	7	6	5	4	3	2	1
7	Helping and encouraging others, volunteering, giving advice	7	6	5	4	3	2	1
8	Participating in organizations and public affairs	7	6	5	4	3	2	1
9	Learning – attending school, improving understanding, getting additional knowledge	7	6	5	4	3	2	1
10	Understanding yourself – knowing your assets and limitations – knowing what life is about	7	6	5	4	3	2	1
11	Work – job or in a home	7	6	5	4	3	2	1
12	Expressing yourself creatively	7	6	5	4	3	2	1
13	Socializing – meeting with other people, doing things, parties, etc...	7	6	5	4	3	2	1
14	Reading, listening to music, or observing entertainment	7	6	5	4	3	2	1
15	Participating in active recreation	7	6	5	4	3	2	1
16	Independence, doing for yourself	7	6	5	4	3	2	1

PLEASE TURN FORM OVER AND COMPLETE THE BRIEF INVENTORIES ON THE OTHER SIDE

Instructions: Indicate how much you've been bothered by each during the past week, including today, by circle in the column that most closely corresponds to how you've been feeling.

mild - *It did not bother me much*

moderate - *It was very unpleasant but I could stand it*

severe - *I could barely stand it*

		not at all	mild	moderate	severe
1	Numbness or tingling	0	1	2	3
2	Feeling hot	0	1	2	3
3	Wobbliness in legs	0	1	2	3
4	Unable to relax	0	1	2	3
5	Fear of the worst happening	0	1	2	3
6	Dizzy or lightheaded	0	1	2	3
7	Heart pounding or racing	0	1	2	3
8	Unsteady	0	1	2	3
9	Terrified	0	1	2	3
10	Nervous	0	1	2	3
11	Feelings of choking	0	1	2	3
12	Hands trembling	0	1	2	3
13	Shaky	0	1	2	3
14	Fear of losing control	0	1	2	3
15	Difficulty breathing	0	1	2	3
16	Fear of dying	0	1	2	3
17	Scared	0	1	2	3
18	Discomfort in abdomen	0	1	2	3
19	Faint	0	1	2	3
20	Face flushed	0	1	2	3
21	Sweating (not due to heat)	0	1	2	3

Clinician use only

BAI	
BDI-PC	
QOL	

Instructions: Please pick the one statement from each section that best describes the way you have been feeling during the past 2 weeks, including today. Circle the number beside the appropriate statement.

1	Sadness	I do not feel sad	0
		I feel sad much of the time	1
		I am sad all the time	2
		I am so sad or unhappy I can't stand it	3
2	Pessimism	I am not discouraged about my future	0
		I feel more discouraged about my future than I used to be	1
		I do not expect things to work out for me	2
		I feel my future is hopeless and will only get worse	3
3	Past Failure	I do not feel like a failure	0
		I have failed more than I should have	1
		As I look back, I see a lot of failures	2
		I feel I am a total failure as a person	3
4	Self-Dislike	I feel the same about myself as ever	0
		I have lost confidence in myself	1
		I am disappointed in myself	2
		I dislike myself	3
5	Self-Critical	I don't criticize or blame myself more than usual	0
		I am more critical of myself than I used to be	1
		I criticize myself for all my faults	2
		I blame myself for everything bad that happens	3
6	Suicidal Thoughts Or Wishes	I don't have any thoughts of killing myself	0
		I have thoughts of killing myself, but I would not carry them out	1
		I would like to kill myself	2
		I would kill myself if I had the chance	3
7	Loss of Interest	I have not lost interest in other people or activities	0
		I am less interested in other people or things than before	1
		I have lost most of my interest in other people or things	2
		It's hard to get interested in anything	3



ABC THERAPY

PSYCHOSOCIAL QUESTIONNAIRE

Patient name _____ SS #: _____ Date: _____

Presenting Problems _____

Duration _____

Additional information _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None? This symptom not present at this time. **Mild?** Impacts quality of life, but no significant impairment of day to day functioning. **Moderate?** Significant impact in quality of life/day to day functioning. **Severe?** Profound impact on quality of life and/or day to day functioning.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood	()	()	()	()	appetite disturbance	()	()	()	()
Sleep disturbance	()	()	()	()	fatigue	()	()	()	()
Poor concentration	()	()	()	()	hopelessness	()	()	()	()
Poor grooming	()	()	()	()	worthlessness	()	()	()	()
Mood swings	()	()	()	()	guilt	()	()	()	()
Emotionality	()	()	()	()	elevated mood	()	()	()	()
Irritability	()	()	()	()	hyperactivity	()	()	()	()
Anxiety	()	()	()	()	emotional trauma victim	()	()	()	()
Panic attacks	()	()	()	()	physical trauma victim	()	()	()	()
Obsessions	()	()	()	()	sexual trauma victim	()	()	()	()
Bingeing	()	()	()	()	substance abuse	()	()	()	()
Anorexia	()	()	()	()	grief	()	()	()	()
Paranoia	()	()	()	()	aggressiveness	()	()	()	()
Sexual dysfunction	()	()	()	()	hallucinations	()	()	()	()

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient Psychotherapy? () NO () YES

If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____.

Prior inpatient treatment for psychiatric, emotional or substance use disorder? () NO () YES

If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____.

Inpatient facility name _____ City _____ State _____ Phone _____ Diagnosis _____ Intervention Modality _____ Beneficial? _____

Prior or current psycho tropic medication usage? () NO () YES

If yes	Medication	Dosage	Frequency	Start	End	Physician

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Entire	Part	Not present
Mother			
Father			
Brother			
Sister			
Other			

Parents current status

_____ married to each other
_____ separated for _____ years
_____ divorced for _____ years
_____ mother remarried _____ times
_____ father remarried _____ times
Other _____

Describe parents: Father

Full name _____
Occupation _____
Education _____
General health _____

Mother

Clients' childhood family experience:

- () outstanding home environment () chaotic home environment () witnessed physical/verbal abuse
() normal home environment () experienced physical / verbal / sexual abuse to others

Age of emancipation and circumstances _____

Marital status:

- () single, never married
() engaged—months
() married fro—years
() divorced for—years
() separated for—years
() live in for —years

Intimate relationship:

- () never been in a serious relationship
() not currently in a relationship
() currently in a serious relationship

Relationship satisfaction:

- () very satisfied
() somewhat satisfied
() unsatisfied

List persons currently living with patient:

Name	Relationship
_____	_____
_____	_____
_____	_____

List children not living with patient:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

Client name _____

Date: _____

MEDICAL HISTORY:

Describe current physical health ☐ Good ☐ Fair ☐ Poor Known allergies: _____

List any medication currently being taken _____

Is there a history of any of the following in the family?

☐ emotional problems ☐ behavioral problems ☐ mental retardation ☐ birth defects ☐ diabetes ☐ cancer ☐ alcoholism
☐ drug abuse ☐ high blood pressure ☐ Alzheimer's disease ☐ stroke ☐ hearts disease

SUBSTANCE USE HISTORY (check all that applies for patient).

Family alcohol/drug abuse history:

☐ father ☐ stepparent/live in
☐ mother ☐ uncle(s) aunt(s)
☐ grandparents ☐ spouse/significant other
☐ siblings ☐ children
☐ other _____

Substances used by Client:

(all that apply)	First use age	Last use age	Frequency
☐ alcohol	_____	_____	_____
☐ meth/amphetamine	_____	_____	_____
☐ cocaine	_____	_____	_____
☐ crack cocaine	_____	_____	_____
☐ marijuana-weed	_____	_____	_____
☐ spice	_____	_____	_____
☐ Heroin	_____	_____	_____
☐ Opiates	_____	_____	_____
☐ PCP	_____	_____	_____
☐ hallucinogens (Lsd)	_____	_____	_____
☐ Bath salts	_____	_____	_____
☐ barbiturates/downers	_____	_____	_____
☐ inhalants	_____	_____	_____
☐ nicotine	_____	_____	_____
☐ caffeine	_____	_____	_____
☐ prescription	_____	_____	_____

Clients' substance use status:

☐ no history of abuse
☐ active abuse
☐ early full remission
☐ early partial remission
☐ sustained full remission
☐ sustained partial remission

Treatment history:

☐ Outpatient (age(s)) _____
☐ inpatient (age(s)) _____
☐ 12 step program _____
☐ stopped on own (age) _____

Consequences of substance abuse: (check all that apply)

☐ hangovers ☐ withdrawal symptoms ☐ sleep disturbance
☐ binges ☐ medical conditions ☐ assaults ☐ job loss
☐ blackouts ☐ change in tolerance ☐ arrests ☐ overdose
☐ Loss of control amount used ☐ relationship conflicts

Describe any significant developmental history:

Social interaction:

- ☐ normal social interaction ☐ inappropriate sex play
☐ Isolates self ☐ dominates others
☐ very shy ☐ associates with acting out peers
☐ alienates self ☐ other _____

Intellectual/academic functioning:

- ☐ normal intelligence ☐ authority conflicts
☐ high intelligence ☐ attention problems
☐ learning problems ☐ underachieving
☐ mild retardation ☐ moderate retardation

SOCIO-ECONOMIC HISTORY (check all that apply)

Living situation:

- ☐ housing adequate
☐ homeless
☐ housing overcrowded
☐ dependent on others
☐ housing deteriorating
☐ living companions dysfunctional

Social support system:

- ☐ supportive network
☐ few friends
☐ substance use-based friends
☐ no friends
☐ distant from family of origin

Sexual history:

- ☐ heterosexual orientation ☐ currently sexually dissatisfied
☐ homosexual orientation ☐ first sex experience (age) _____
☐ bisexual Orientation ☐ age 1st pregnancy/fatherhood _____
☐ currently sexually active ☐ history of promiscuity age _____
☐ history of unsafe sex age _____ to _____

Additional information _____

Employment:

- ☐ employed and satisfied
☐ unemployed
☐ Co-worker conflicts
☐ supervisor conflicts
☐ unstable work history
☐ disabled

Financial Situation:

- ☐ no current financial problems
☐ large indebtedness
☐ poverty or below poverty income
☐ impulsive spending
☐ relationship conflicts over finances

Legal History:

- ☐ no legal problems
☐ now on parole / probations
☐ arrests no substance related
☐ arrests substance related
☐ court ordered this treatment
☐ jail / prison _____ times / total times served _____

Describe any cultural issues that contribute to current problem: _____

Describe current activity in community/religious/re-creational activities: _____

SOURCES OF DATA PROVIDED ABOVE: ☐ PATIENT SELF REPORT FOR ALL _____

☐ PATIENT PARENT OR GUARDIAN _____

☐ OTHER (SPECIFY) _____

