

CHART #: \_\_\_\_\_  
D.O.B \_\_\_\_\_  
SECTION #: \_\_\_\_\_ PAGES: \_\_\_\_\_  
INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

## INTAKE PAPERWORK FACESHEET

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CHART # \_\_\_\_\_

DATE INTAKE PAPERWORK TURNED IN: \_\_\_\_\_

ADULT OR CHILD (CIRCLE ONE)

MH or AOD (CIRCLE ONE)

INSURANCE: \_\_\_\_\_ (INTAKE USE ONLY)

MITTS/INSURANCE \_\_\_\_\_

INITIALS \_\_\_\_\_

DEMOGRAPHICS \_\_\_\_\_

INITIALS \_\_\_\_\_

OFFENDER SEARCH \_\_\_\_\_

INITIALS \_\_\_\_\_

INTAKE LIST \_\_\_\_\_

INITIALS \_\_\_\_\_

WAITLIST \_\_\_\_\_

INITIALS \_\_\_\_\_

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NOTES:

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SCHEDULED DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

THERAPIST: \_\_\_\_\_ LOCATION: \_\_\_\_\_

INITIALS OF WHO SCHED. THE APPT: \_\_\_\_\_ INITIALS OF SCANNED: \_\_\_\_\_

**Access Counseling Service  
DEMOGRAPHIC INFORMATION**

Chart# \_\_\_\_\_  
 D.O.B. \_\_\_\_\_ Section \_\_\_\_\_  
 Initials \_\_\_\_\_ Pages \_\_\_\_\_

Client Name (First, MI, Last)		Client No.		Today's Date	
Address		City		State	
Primary					
Local <input type="checkbox"/> Same as Primary					
Billing <input type="checkbox"/> Same as Primary					
County of Legal Residence <input type="checkbox"/> Out of State <input type="checkbox"/> Unknown					
Home Phone (    )		Work Phone (    )		Other Phone (    )	
Where may we contact you? <input type="checkbox"/> Primary Address <input type="checkbox"/> Local Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Other Phone			Where may we leave a message? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other:		
Client Age		DOB (MM/DD/YYYY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Separated <input type="checkbox"/> Other:		Soc. Sec. No.			
Race <input type="checkbox"/> W – White <input type="checkbox"/> N – Native Am. <input type="checkbox"/> P – Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Multiple Race <input type="checkbox"/> B – Black/African Am. <input type="checkbox"/> A – Asian <input type="checkbox"/> M – Alaskan Native <input type="checkbox"/> Unknown					
Ethnicity <input type="checkbox"/> A – Puerto Rican <input type="checkbox"/> B – Mexican <input type="checkbox"/> C – Cuban <input type="checkbox"/> D – Other Hispanic <input type="checkbox"/> E – Not Hispanic or Latino					
Parent/Guardian/Custodian if Minor (include name and address)				Parent/Guardian/Custodian Phone (    )	
Emergency Contact (name and address)			Relationship		Emergency Contact Phone (    )
Primary Language		Client needs the assistance of an interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes <input type="checkbox"/> American Sign Language <input type="checkbox"/> Language Interpreter (specify):			
Client needs assistance with visualization of material or alternate format? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Advance Directive? <input type="checkbox"/> Yes    If yes, request a copy of the directive. <input type="checkbox"/> No    If no, ask if client needs assistance in obtaining an advance directive.					
<b>Payers</b>					
Medicaid <input type="checkbox"/>		Medicaid No.		Medicare <input type="checkbox"/>	
EAP Involved/Eligible <input type="checkbox"/>		Company Name			No. of Visits
Primary Private Insurance			Insurance Plan No.		Group No.
Secondary Private Insurance			Insurance Plan No.		Group No.
<input type="checkbox"/> Workers Comp <input type="checkbox"/> Veteran <input type="checkbox"/> Self		Other (specify) <input type="checkbox"/>		Other (specify) <input type="checkbox"/>	

Client Name: \_\_\_\_\_

\*\* IF CLIENT IS A CHILD: \_\_\_\_\_ GRADE CURRENTLY IN \_\_\_\_\_  
NAME OF SCHOOL

MONTHLY HOUSEHOLD INCOME: \$ \_\_\_\_\_ NUMBER OF DEPENDENTS IN HOUSEHOLD \_\_\_\_\_

PLEASE GIVE US A BRIEF DESCRIPTION OF THE PROBLEM OR WHY YOU WERE REFERRED HERE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>**URGENCY SCORE** (CIRCLE ONE)</b>	0	RECENT DISCHARGE FROM HOSPITAL – CURRENTLY SUICIDAL / HOMICIDAL
	1	CLIENT STATES NEED TO GET IN WITHIN THE WEEK – PREGNANT, IV DRUG USE, SUICIDE ATTEMPT WITHIN THE PAST 30 DAYS, HIV POSITIVE
	2	CLIENT STATES NEED TO GET IN WITHIN SEVERAL WEEKS
	3	CLIENT OPEN TO APPOINTMENT TIMES

DO YOU HAVE ANY PREFERENCE AS TO THE TYPE OF THERAPIST YOU WOULD LIKE ASSIGNED TO YOU?  
(IE: MALE / FEMALE, CHRISTIAN BASED, HAS A PARTICULAR BELIEF OR VALUE SYSTEM)

IF SO PLEASE INDICATE: \_\_\_\_\_

\*\*ARE YOU CURRENTLY IN THERAPY OR PSYCHIATRIC SERVICES SOMEWHERE ELSE? Y/N  
IF YES, WHERE? \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED COUNSELING HERE OR AT OTHER PLACES FOR EMOTIONS, MENTAL HEALTH OR  
SUBSTANCE ABUSE PROBLEMS? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHEN? \_\_\_\_\_ WHERE? \_\_\_\_\_ WHAT FOR? \_\_\_\_\_

\*\*\*\*\*  
(IF CHEMICAL DEPENDENCY PROBLEM AND FEMALE) ARE YOU PREGNANT? \_\_\_\_\_ YES \_\_\_\_\_ NO

DO YOU HAVE A CDL LICENSE? \_\_\_ YES \_\_\_ NO ARE YOU D.O.T. REGULATED? \_\_\_ YES \_\_\_ NO

**IN ORDER TO BILL INSURANCE, WTHE FOLLOWING MUST BE COMPLETED ON THE POLICY HOLDER**

Primary Insurance: \_\_\_\_\_

Subscriber Name Social Security Number Birthdate

Relationship to Client Employer Name

Secondary Insurance: \_\_\_\_\_

Subscriber Name Social Security Number Birthdate

Relationship to Client Employer Name

## ACCESS COUNSELING SERVICES, LLC

# CONSENT FOR TREATMENT FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

I hereby authorize Access Counseling Services, LLC to utilize customary behavioral health treatment services, including chemical dependency, in providing care for: (Name of client) \_\_\_\_\_

These services will be provided by Access Counseling Services, LLC staff or consultants. I concur with the following: I have received the statement of the Notice of Privacy Practices, Client Rights and I have accepted my initial fee agreement. I will participate in forming a plan for my child's / my own treatment as my signature on the individual service plan will affirm. Further, I understand that while counseling and other services provided by the agency offer reasonable expectation of benefit, there is no certainty of success. There may be minimal risk inherent in any psychiatric, psychological, or behavioral health counseling intervention and I can expect that any reasonable or anticipated risks will be discussed with me. I understand that it is my responsibility to inform Access Counseling Services, LLC service providers of any problems or side effects that may develop in the course of my treatment so that they may be addressed and do so early enough in session to allow for processing without going over my allotted time.

Access Counseling Services, LLC recognizes and affirms a person's right to refuse or withdraw consent for treatment. In this event, efforts to develop alternative approaches in collaboration with the person served will be made to ensure that the person receives needed services. If consent for treatment is still withdrawn or revoked, efforts will be made to ensure that the person understands the implications and consequences of not receiving treatment.

I understand that all records and reports are considered confidential and will not be released to any individual or agency without my prior written authorization. However, information may be released without my prior authorization under the following circumstances:

1. Upon receipt of a subpoena Duces Tecum.
2. In the event of a medical emergency.
3. If there is evidence to suggest that child abuse has occurred.
4. To validate an insurance claim and then only information sufficient to substantiate claim.
5. Release authorized in accordance with state and/or federal laws and regulations pertaining to professional standards review.
6. To qualified personnel for research, audit or program evaluation.
7. To comply with federal laws and regulations about a crime committed by a client, either at the program or against any person who works for the program or about any threat to commit such a crime.
8. In the event of communicated harm to self or others.
9. To my therapist's supervisor or in peer review with other agency clinicians who are also bound to protect client confidentiality.

Confidentiality of alcohol and drug abuse client records maintained by this program is protected by Federal Law and Regulations. Violation of this by a program is a crime. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part b, paragraph 2.22, for Federal Regulations.)

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

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

Relationship: Self: \_\_\_\_\_ Parent: \_\_\_\_\_

Guardian: \_\_\_\_\_

Staff: \_\_\_\_\_

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

**ACCESS COUNSELING SERVICES, LLC**  
**FINANCIAL POLICY AND AGREEMENT for Mental Health and AOD Services**

We are committed to providing you with the best possible care and would be happy to discuss our financial fees with you at any time.

\*CO PAYMENTS OR FULL PAYMENT IF DEDUCTIBLE APPLIES, ARE DUE AT TIME OF SERVICE

\*WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER

**Insurance:** If you have insurance, we will help you receive maximum benefits. You are responsible for providing all insurance coverage information and establishing the primary and secondary coverage at the time of service. We will accept and file your insurance if we are a provider on your plan. Your insurance coverage is a contract between you and your insurance carrier. All co pays must be paid at the time of service. If your insurance requires a deductible before they will pay, you will be responsible for your deductible until it is paid. Once we file your insurance, if payment is not received within 60 days, you will need to submit the payment for the balance due or make payment arrangements with our office.

**Minor Children:** The parent(s) or guardian who brings a child to therapy or psychiatrist appointment is responsible for the copay and/or deductible. It is our policy to consider an 18 year old who is still in high school a "minor". Insurance billing for the minor is the same as the above section on Insurance.

As an Access Counseling Services, LLC client, the following fees apply for services received.

<u>Service</u>	<u>Mental Health Fees</u>	<u>AOD Fees</u>	<u>Self Pay Fees (For Office Use Only)</u>
INTAKE with Therapist (1-hour)	\$ 143.05	\$ 143.05	\$
PER SESSION with Therapist (1-hour)	\$ 121.07	\$ 121.07	\$
INTAKE with doctor (1-hour)	\$ 236.92	\$ 236.92	\$
PER SESSION with doctor (20-30 minutes)	\$ 178.08	\$ 178.08	\$
PER SESSION with nurse (1-hour)	\$ 127.68	\$ 127.68	\$
PER SESSION for Group (1-hour)	\$ 41.00	\$ 41.00	\$
PER SESSION for Case Management (1- hour)	NA	\$78.16	\$
Urine Drug Screen	NA	\$ 14.48	\$
CPST Individual (1-hour)	\$ 78.16	NA	\$
CPST Group (1-hour)	\$ 35.96	NA	\$
INTENSIVE OUTPATIENT (IOP) (Day)	NA	\$ 149.88	\$
CRISIS INTERVENTION (1- hour)	\$ 112.27	\$ 112.27	\$

**Missed Appointments:**

\*If you miss or cancel (without 24 hours' notice) three consecutive appointments your case will be reviewed by your treatment team for closure.

\*If you miss or cancel (without 24 hours' notice) three appointments within a calendar year your case will be reviewed by your treatment team for closure.

\*Referrals will be made for discharge planning.

\*You may reapply for reinstatement, but you will have to go through the intake process again and your commitment to treatment will be reassessed along with other established criteria to determine if you can resume services at Access Counseling Services.

I understand that all payments are made at the time of service. I also understand that my services may be reduced and/or interrupted if I am unable to pay. I understand that only payment arrangements that are approved by the Executive Director/CEO, or her designee, are valid. I understand I can contact Deanna Proctor, Executive Director/CEO and Client Rights Officer with any questions.

\_\_\_\_\_  
 Client Name

\_\_\_\_\_  
 Responsible Party Name

\_\_\_\_\_  
 Client or Responsible Party Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Signature

\_\_\_\_\_  
 Date

ID No. \_\_\_\_\_ Rev. 11/21

**Access Counseling Services, LLC  
Tele-Health Informed Consent**

Tele-Health is the practice of delivering health care services via technology assisted media or other electronic means (phone, computer, tablets) between a practitioner/therapist/case manager and a client/patient who are in two different locations.

I understand the following with respect to tele-health services:

1. I understand that I have the right to withdraw consent at any time.
2. I understand that there are risks, benefits, and consequences associated with tele-health, including but not limited to:
  - a. Disruption of transmission by technology failures,
  - b. Interruption and/or breaches of confidentiality by unauthorized persons,
  - c. Limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party.
4. I understand that all information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law i.e. child or elder abuse, danger to self or others, third party payers.
5. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-health unless an exception to confidentiality applies i.e. child or elder abuse, danger to self or others, third party payers.
6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-health services are not appropriate and a higher level of care is required.
7. I understand that during a tele-health session, technical difficulties could occur and result in service interruptions. If this occurs, end and restart the session. If unable to reconnect within ten minutes, please call to re-schedule. If you are having an emergency when service is interrupted, call 911 or go to the ER first, and then contact your provider.
8. I understand that my provider(s) may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I agree to update my location and emergency contact information at the beginning of each session. An emergency contact person may be contacted on your behalf in a life-threatening emergency only. The person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

I have read and understand the information provided above. My signature below indicates agreement with the above terms and my consent to participate in tele-health services.

\_\_\_\_\_  
Signature of Client, Parent, Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

## ***ACCESS COUNSELING SERVICES***

### ***Procedure for Minors Receiving Psychiatric Services***

In order for a minor (under age 18) to see the psychiatrist and for medication changes to occur, there must be a parent or legal guardian present to give informed medical consent.

For example: Foster parents do not have legal guardianship and do not have legal rights to consent to medical care. The child is considered in the custody of Children's Services; therefore, a representative from Children's Services must be present for the psychiatrist sessions in order for medications to be prescribed or to make changes in currently prescribed medications.

I have read and understand I must be present for psychiatric appointments.

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Parent/Legal Guardian

Date

Retain signed copy for clinical record; give copy to parent/legal guardian.