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INTAKE PAPERWORK FACE SHEET

CLIENT NAME _____ **DOB:**_____

CHART # _____

DATE INTAKE PAPERWORK TURNED IN _____

ADULT OR **CHILD (CIRCLE ONE)** **MH** OR **AOD (CIRCLE ONE)**

INSURANCE: _____**(INTAKE USE ONLY)**

INTAKE LIST _____ **INITIALS** _____

OFFENDER SEARCH _____ **INITIALS** _____

WAITLIST _____ **INITIALS** _____

DEMOGRAPHICS _____ **INITIALS** _____

MITS/INSURANCE _____ **INITIALS** _____

NOTES : _____
_____
_____

SCHEDULED DATE _____ **TIME:** _____

THERAPIST _____ **LOCATION:** _____

INITIALS OF WHO SCHED. THE APPT: _____ **INITIALS OF SCANNED:** _____

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☐ Check if Annual Update

Access Counseling Service

DEMOGRAPHIC INFORMATION

Client Name (First, MI, Last)	Client No.	Today's Date

Address	City	State	Zip
Primary			
Local ☐ Same as Primary			
Billing ☐ Same as Primary			

County of Legal Residence
☐ Out of State ☐ Unknown

Home Phone	Work Phone	Other Phone
( )	( )	( )

Where may we contact you?
☐ Primary Address ☐ Local Address ☐ Billing Address
☐ Home Phone ☐ Work Phone ☐ Other Phone

Where may we leave a message?
☐ Home ☐ Work
☐ Other:

Client Age	DOB (MM/DD/YYYY)	Gender	Soc. Sec. No.
		☐ Male ☐ Female	

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Other:

Race
☐ W – White ☐ N – Native Am. ☐ P – Native Hawaiian/Other Pacific Islander ☐ Multiple Race
☐ B – Black/African Am. ☐ A – Asian ☐ M – Alaskan Native ☐ Unknown

Ethnicity
☐ A – Puerto Rican ☐ B – Mexican ☐ C – Cuban ☐ D – Other Hispanic ☐ 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?
	☐ No ☐ Yes If yes ☐ American Sign Language ☐ Language Interpreter (specify):

Client needs assistance with visualization of material or alternate format?
☐ No ☐ Yes

Advance Directive?
☐ Yes If yes, request a copy of the directive.
☐ No If no, ask if client needs assistance in obtaining an advance directive.

Payers

Medicaid ☐ Medicaid No.	Medicare ☐ Medicare No.	
EAP Involved/Eligible ☐ Company Name		No. of Visits
Primary Private Insurance	Insurance Plan No.	Group No.
Secondary Private Insurance	Insurance Plan No.	Group No.

☐ Workers Comp ☐ Veteran ☐ Self	Other (specify) ☐	Other (specify) ☐

CHART # _____
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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:

_____

_____

_____

URGENCY SCORE (CIRCLE ONE)	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

CHART # _____
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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- PRINT) _____

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 Signature: _____ Date: _____

CHART # _____
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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, in addition to secondary telehealth group.

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, 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 health 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.

Uninsured or Self-Pay Patients: If you do not have health insurance, or have health insurance but intend to pay out of pocket for the services you receive at Access Counseling Services, you are entitled to a good faith estimate of the expected charges for which you will be responsible. The estimate must be provided to you within a reasonable time after you request it or schedule your services. ***If you are an uninsured or self-pay client***, please initial below to acknowledge that you are aware of your right to receive a good faith estimate. Client Initials: _____

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

Service	Mental Health Fees	AOD Fees	Self-Pay Fees (may refer to separate good faith estimate)
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. 1/22

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ACCESS COUNSELING SERVICES

PROCEDURE FOR MINORS RECEIVING PSYCHIATRIC SERVICES

Client Name (PRINT): _____

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

For example: Foster parents do not have legal guardianship and do not have legal rights to consent to treatment. The child is considered in the custody of Children's Services; therefore, a representative from Children's Services must be present for the prescriber 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 prescriber appointments.

Parent/Legal Guardian Date