eunoia counseling

Client Intake Form

	County of Residence	SS Number	Race	Sex	Religion	Date of Birth
	Address		Apt #	City	State	Zip
	Phone #	Alt. Phone #		Physician Name		Physician Phone #
	Marital Status	Guardianship	Employer	Employer Address		Employer Phone #

Responsible Party Information

If same as client information, put an “X” on the line and skip to emergency contact __________

Name	Relationship	SS Number	Address	Phone	Work Phone
Emergency Contact	Relationship	Address	other than living in your home	Phone	
1					
2					
3					

Insurance Company Name	Policy Number	Name of Subscriber	DOB of Subscriber	Deductible	Co-Pay
Have you applied for Medicaid?	Medicaid #		Have you applied for Disability Insurance?	Are you receiving Disability?	
Yes____ No____			Yes____ No____	Yes____ No____	

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Client Name: ______________________

Initial Intake Information

At Eunoia Counseling, we strive to provide individuals and families with the support they need with therapy or counseling. We believe in meeting people where they are at and giving them the building blocks to create strong futures. Our passion lies in helping people find the strength in themselves to achieve success. Eunoia Counseling values treating people with dignity, respect and compassion.

At Eunoia Counseling, the staff is highly trained with experience in Outpatient Substance Abuse Treatment, trauma treatment including EMDR (Eye Movement Desensitization & Reprocessing), Play Therapy, and many types of outpatient mental health therapy such as family therapy, couples counseling, and individual therapy. Staff have training and experience in the areas of child welfare, foster care, child development, family dynamics, behavior management, mental illness, and other areas that influence a healthy state of mind.

Therapy:
Therapy is interpersonal treatment for problems in living, functioning and overall wellbeing. It involves talking with a trained professional about conditions ranging from depression and anxiety, to relationship problems and career/school frustration. Therapy provides ways to understand and express feelings, understand patterns of thinking, gain perspective on past and current relationships, set goals, and clarify dreams for the future.

Your treatment plan begins with you and your therapist discussing your needs and goals using a Psychosocial Assessment. This simply means that you counselor will meet with you and ask you several questions to assess your current situation and needs. Some questions will regard your physical and mental health, substance abuse, family and social life, strengths, developmental history and risk assessment. After this assessment you and your therapist will decide on what course of treatment will work best for you.

Mental Health treatment is a process and recovery and healing. Please discuss all concerns and needs with your therapist throughout the course of your treatment. Teamwork with identifying factors that contribute to your current symptoms is key to your reaching the best possible outcome in treatment.

Eunoia Counseling…healthy is a state of mind.

Client Name: ______________________

Rights and Responsibilities

All clients of Eunoia Counseling have the following Rights and Responsibilities

- The right to receive considerate and respectful treatment
- The right o treatment based on need for treatment
- The right to treatment without discrimination based on race, color, creed, national origin, gender, marital status, sexual orientation, age, religion, veteran status, political belief, physical or mental disability, or any other characteristic protected by law.
- The right to receive treatment in the least restrictive setting
- The right to confidentiality of their treatment record and communications pertaining to their treatment.
- The right to written consent for the release of any information pertaining to their treatment record with exception to court testimony
- The right to be informed that all staff are mandatory reporters of suspected child abuse/dependent adult use and neglect
- The right to be informed of and refuse the use of any recording equipment used
- The right to participate in individualized treatment and implementation of treatment
- The right to know the name and responsibilities of staff involved in their treatment and be informed of any changes in their treatment team
- The right to refuse a specific treatment and to know of other treatment options
- The right to request a review of individualized treatment plan or seek the opinion of outside consultants at their own expense
- The right to express concerns about their treatment up to and including filing a written grievance
- The right to receive a copy of their rights and responsibilities and any other forms that they have signed upon written request.

Client's Responsibilities

- Be on time for appointments
- Call in a timely manner if need to reschedule or cancel an appointment
- Demonstrated respect for self, others and property
- Respect the confidentiality of others
- Respect our smoke free and drug free facilities
- Responsible for retraining from the use of alcohol and/or illegal substances prior to or during appointments
- Responsible for payment of services as applicable

Grievance Procedure

The purpose of the client grievance procedure is to provide the opportunity for recourse when you are unhappy with the services received or decisions that are made by the staff. Eunoia Counseling views your complaint as an opportunity to resolve differences that may exist between you and the staff or

agency polities. It is our hope that any problems you experience can be worked out between you and the staff you are working with. If this is not possible the following procedure is available to assist you in resolving your complaint.

1. You will be responsible for contracting a managing partner to set up a meeting between yourself and the staff with a managing partner present. You may discuss your concern(s) with any managing partner.
2. If you are not satisfied with that response you may address a written complaint to all managing partners; this will be reviewed, and you will receive a written response within 10 working days of receipt of complaint.
3. If you are receiving services purchased by the Department of Human Services or Medicaid, you have the option of contacting them any time.
4. You have the right to file a complaint with the licensing board, if appropriate, or the Department of Human Services at any time.

Confidentiality Policy

Eunoia Counseling observes all federal and state laws and regulations as they relate to confidentiality. All treatment records are kept behind double lock and day or secured password. Records are kept for a minimum of five years after case closure and are then shredded and disposed of in accordance with stated and federal guidelines. Information may be shared with other employees of Eunoia Counseling as deemed relevant and pertinent to providing the best service to the client.

Eunoia Counseling may not collect or release information without an authorization for release of information signed by the client or legal representative. Clients have the right to revoke authorization for release of information at any time. All clients receive notification of privacy practices. All staff of Eunoia Counseling are aware of confidentiality before any interaction or exposure to client information. Notice to clients that in certain cases Eunoia Counseling staff may give and exchange information with the Iowa Department of Human Services and the Iowa Juvenile Courts without needing a release of information. Eunoia Counseling Service operates in accordance with the Iowa Code Section 228.

Abuse Reporting Policy

All staff employed by Eunoia Counseling that provide client services are mandatory reports of child abuse. Office support staff are not considered providers.

Staff will file a report if:

1. The victim is a child
2. The child is subjected to one or more of the following **nine categories** of child abuse defined in Iowa Code Section 232.2
   a. Physical Abuse
   b. Mental Injury
   c. Sexual Abuse
   d. Child prostitution
   e. Presence of Illegal Drugs
   f. Denial of Critical Care
   g. Manufacturing or Possession of a Dangerous Substance defined in Iowa Code 232.2
   h. Bestiality in the Presence of a Child
   i. Co-Habitating with a Sex Offender
3. The abuse is the result of the acts of omissions of the person responsible for the care of the child. Eunoia Counseling will abide by all state and federal guidelines and rules regarding abuse

reporting. Staff are required to make a verbal report within 24 hours of learning of suspected abuse and file a written report within 48 hours of suspected abuse. Release of information is not required for reporting suspected abuse. To report suspected child abuse, call 1-800-362-2178.

Records

It is required by law to maintain records each time a session occurs. The records contain sensitive information including observational data, diagnosis, treatment plans, and other clinically relevant information. During treatment, information may be provided to insurance companies, managed care companies, and/or courts. Records will be shared, in part or full, with you as the client if requested.

Termination

Termination of the counselor-client relationship can occur in several different contexts, but it is important that we be prepared for a termination phase from the outset of services. You can choose to terminate services at any time. You have a right to expect that the relationships will be terminated when you have realized maximum benefit from it or have achieved the goals that are made at outset.

Manage Care Limitations

Eunoia Counseling is committed to providing the highest quality care available; however, limitations on the ability to provide that level of care are sometimes affected by insurance and/or managed care providers. Limitations can affect service process, length of treatment, number of sessions, and amount of money that will be reimbursed. In some cases, managed care guidelines may affect the content of the services. These considerations, if they apply, will sometimes affect outcomes. In addition, if you wish to utilize a 3rd party payer, employees of Eunoia Counseling must be able to discuss your diagnosis and treatment with representatives of your EAP, managed care, or insurance.

Emergencies

In the event of an emergency, for which you feel immediate attention is necessary; your provider will make reasonable efforts to make themselves available. If they are not immediately available and you reach voicemail, please leave a message indicating that the call is urgent. Please contact **911 immediately or proceed to the nearest emergency room** for immediate evaluation. The following numbers can also assist you in the event of a crisis:

Mobile Crisis Unit	1-844-430-8520
Suicide Hotline	1-800-273-8255
United Way	211 or 1-800-244-7431
Oskaloosa Police Department	641-672-2557

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Client Name: ________________________

Patient Informed Consent / Consent for Treatment

I have chosen to receive treatment services through Eunoia Counseling. The type and extent of services I will received will be based on a discussion with me (the client/legal representative) and following an initial assessment (if appropriate to the services requested).

I understand that there is no assurance that I will feel better because services are a cooperative effort between my provider and me. I will work with my counselor in a cooperative manner to resolve my difficulties. I understand that if using a third-party payer Eunoia Counseling may be required to provide a diagnosis to describe my condition. Once that is provided, Eunoia Counseling, LLC or its employees can accept no liability for impacts to insurability or employment.

I understand that all information shared with the providers at Eunoia Counseling is confidential and no information will be release without my consent. I also understand that there are expectations to this detailed below.

I understand that the state and local laws require that my counselor report the following:

1. When there is risk of imminent danger to me or to another person the counselor is ethically bound to take necessary steps to prevent such danger.
2. When there is a suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the counselor is legally required to take steps to protect the child, and to inform the proper authorities.
3. When a valid court order is issued for medical records, the counselor and the agency are bound by law to comply with such requests.
4. Eunoia Counseling may occasionally find it helpful or necessary to consult other professionals about a case. During collaboration, every effort is made to avoid revealing the identify of a client. The professionals involved in consultation are also legally bound to keep the information confidential. If you do not object, Eunoia Counseling staff will not tell you about these consultations unless it is important in our work together.

   If I have questions regarding this consent form or about the services offered at Eunoia Counseling, I may discuss them with my provider. I have read and understand the above. I consent to participate in the services offered to me by Eunoia Counseling. I understand that I may stop services at any time. I understand that I can revoke my consent at any time except to the extent that if I do not revoke this consent, it will expire automatically one year after all claims for services have been paid. I also understand that I have the right to inspect records pertaining to my treatment.

____ ____________________

Patient (if over age 18) or Parent/Legal Representative Signature Date

____

Relationship to Client / Printed Name

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Authorization to Release Information

I authorize Eunoia Counseling to exchange information with:

Name: ____

Address: ____

Phone #: ____________________________ Fax #: ______________________________

Email Address: ____

This information is pertinent to the client's mental health, behavioral or academic needs as deemed by either agency. This information may contain:

(Place an "X" in front of the information you give permission to exchange)

___Discharge Summaries
___Diagnostic Tests or Assessments
___Attendance in Treatment
___Education Records, Testing Data/Information
___Medical Records
___Psychiatric Assessments/Evaluation/Records
___Clinical Progress Notes
    ___Progress
___Mental Health Treatment Plan
___Police Reports
___Termination/Discharge Summary
___Psychological Assessments/Evaluation Records
___Additional Information as Indicated____

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This information will only be shared with appropriate personnel on a need to know bases. This authorization is good for two years from the date signed. I understand I may revoke this authorization at any time by going written notice to Eunoia Counseling. I understand that any relate made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Specific Authorization for Release of Information Protected by State/Federal Law

I specifically authorize the release of data and information related to:

Yes____ No_____Substance Abuse   Yes____HIV/AIDS Information
Yes____ No_____Mental Health

_____________________________________ __________ ______________________________
Client/Parent/Legal Representative Signature   Date   Witness

PROHIBITION ON REDISCLOSURE: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

*Only persons 18 year of age or his/her legal representative may authorize release of mental health information.
*Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statute.

Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.

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Client Name: ______________________

Service Agreement/Assignment of Benefits/Agreement to Pay

You have chosen Eunoia Counseling to provide services for you and/or your family. I hereby give consent for myself and/or my child named herein to receive therapy and/or skill development services by Eunoia Counseling. My insurance will be notified of my consent to receive services and that information will be shared with my insurance company, for the purpose of payment and service authorization, and agree to assign my insurance benefits to Eunoia Counseling for purpose of payment for services/care rendered and I hereby give consent for information to be shared by and between Eunoia Counseling and the insurance company or other paying agent. I also understand that Eunoia Counseling may use a third-party billing agent and electronic records system that maintains my confidential information.

No information identifying your family will be released or disclosed without written consent by you or a parent or other legally designated representative. You may be asked to sign a specific release of information to any other individual or agencies which staff deems important to communicate with us in the best interest of treatment. Eunoia Counseling will not knowingly utilize any treatment or procedure, which is experimental, controversial or carries intrinsic risk. I understand the assigned therapist may be under supervision such as an intern or practicum students or therapist working toward licensure. I understand that this person will be fully supervised and will share information about your case for supervision purposes only. This may include video or tape recordings of sessions or processing of file notes. This is a mandatory process and is for the benefit of the client and the therapist. None of this information will be used inappropriately.

We/I, the undersigned, agree to accept services from Eunoia Counseling. We agree to cooperate with the requirements for the services for self, our child/family and will be participating in counseling or other services until discharged. I understand that my child may receive services in the office without my presence. The signature below is equivalent to the signature of agreement for the developed treatment plan unless objected to in writing.

We/I, the undersigned, understand that with the proper release, when information needs to be shared quickly, it may be done via fax, phone, or computer email. We/I also understand that individual client records may be kept on computer. We/I understand that there is no guarantee that information we disclose in a group or family setting will be held confidential by other members of the group or family. We/I understand that in the course of treatment, many subjects will be discussed. Some these subjects may be, but are not limited to: age, educational achievement, family background, prior treatment efforts, family relationships, marital issues, sexuality, violence, exposure to/experience of trauma or adverse life events, leisure activities, drug/alcohol usage, medical involvement, housekeeping, shopping habits and hygiene.

We/I understand that it is our responsibility to deep insurance information updated with Eunoia Counseling. We/I further understand that we need to provide a cop of our insurance card to Eunoia Counseling at the beginning/first appointment of each month. **Should I fail to provide updated insurance information, I understand I will be billed the full amount of the service. I also understand and agree to provide 24-hour notice of cancellation and if I fail to do this, I will be charged for the full appointment time and be responsible to pay this charge out of pocket. I understand I will be charged a cancellation fee for the 3rd cancelled appointment.**

We/I further agree to pay Eunoia Counseling the full balance of my account. If I am unable to pay the full balance, I will contact Eunoia Counseling at 641-569-8098 to make acceptable payment arrangements. If this bill is not pain as agreed in full, the balance of the bill for care rendered may be processed through a collection agency. **Medicaid clients are not required to make out of pocket payments.** I agree to pay $__________ per session, at the time of the appointment. This is for Private Pay / Co-Pay / Deductible. **Should my insurance not be valid during the time services are rendered, I agree to pay the current fee per session.**

This agreement will remain in effect until involvement with Eunoia Counseling ends either by discharge or termination of services. This agreement was angered into and signed on the _______ day of __________, 20____. **I hereby acknowledge that I have received and have been given an opportunity to read a copy of Eunoia Counseling Notice of Privacy Practices and Client Rights and Responsibilities. I understand that if I have questions regarding the Notice or my privacy rights, I can discuss this with my therapist.**

_______________________________________ ______________

Signature Date

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Client Name: ________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

Protected Information While working with Eunoia Counseling, information regarding your medical history, treatment, social history, and other issues including payment for services may be created or received by us. Information which can be used to identify you relating to your medical care is protected by state and federal law ("Protected Health Information or Protected Information").
Your Rights Federal law grands your certain rights with respect to you Protected Information. Specifically, you have the right to:
Receive notice of our policies are procedures regarding your Protected Information;
Request that certain uses of your Protected Information be limited; but the request must be in writing and may be denied in certain limited situations;
Access to your Protected Information; but the request must be in writing and may be denied in certain limited situations;
Request that your Protected Health Information be Changed
Obtain an accounting of certain disclosures by us of your Protected Health Information for the past six years;
Revoke in writing any prior authorizations for use or disclosure of Protected Information, except to the extent that action has already been taken; and
Request communications of your Protected Information are done by reasonable alternative means or at alternative locations such as by e-mail.

Our Responsibilities: Federal law also imposes certain obligations on Eunoia Counseling with respect to your Protected Information.

Specifically, we are required to:

1. Provide you with notice of our legal dudes and Eunoia Counseling's policies regarding the use and disclosure of your Protected Information.
2. Maintain the confidentiality of your Protected Information in accordance with stated and federal law and Eunoia Counseling's policies;
3. Review your requested limits regarding the use and disclosure of your Protected Information and inform you if these will restrictions will be used;
4. Allow you to inspect and copy your Protected Health Information in the presence of Eunoia Counseling staff as designated by Eunoia Counseling during our regular business hours pursuant to any legal restrictions. This access may be limited based on various factors including the type of information requested and if the information involves someone other than you;
5. Act on your request to amend Protected Health Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension. Although this does not guarantee that amendment will occur. Eunoia Counseling will determine in its sole discretion if the amendment is appropriate;
6. Accommodate reasonable requests to communicate Protected information by alternative means or methods; and
7. Abide by the terms of this notice.

How Your Protected Information May Be Used and Disclosed: Generally, your Protected Information may be used and disclosed for provision of services, treatment, payment, and for running Eunoia Counseling, or as required by law. Protected Information may be shared/forwarded in person, on the phone, by mail, fax, electronically or other available means. This includes a variety of areas:

Treatment Purposes: We may use or disclose your Protected Information for treatment purposes including continuing care and case or care management. While receiving services from Eunoia Counseling, it may be necessary for various personnel, including, but not limited to, physicians, mental health professionals, therapists, caseworks and others involved in your services to have access to your Protected Heath Information in order to provide you with appropriate services. This may include contract agencies with Eunoia Counseling or other entities you are working with or receiving services from.

Specific Examples include:
1. Records and information may be shared with other Eunoia Counseling staff members for administrative or therapeutic purposes including supervision.
2. To coordinate services among workers, foster parents, and volunteers. Information is to be shared on a need to know basis. All workers, foster parents and volunteers must maintain confidentiality of the information received.
3. When Juvenile Court is involved, records may be shared with Juvenile Court Officers. Information about a child may be shared with the child's Guardian ad Litem.
4. In the event of a legitimate subpoena or court order for court appearance or release of records.
5. In the vents of medical emergency.
6. The receipt of information that suggests child abuse, dependent adult abuse or neglect has occurred. Eunoia Counseling is legally obligated to report any such information to DHS.
7. Under circumstances in which there exists danger to yourself or others.
8. Auditors, including State or Federal Agencies, may review your records to evaluate program effectiveness.

Payment Purposes: Your Protected Information may also be used for disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that treatment and services provided by us may be filled and collected from you, your insurance company, DHS or another group. Bills requesting payment will usually include information which identifies you, services received, and supplies used. It may also be necessary to release Protected Information to obtain prior approval for services or to assess the type of services needed.

Facility Care Operations: Your Protected Information may also be used for Eunoia Counseling operations, to ensure Eunoia Counseling provides the highest quality services. For example, your Protected Information may be used for learning or quality assurance purposes. We may also remove information which could identify you from you record to prevent others from learning who the specific clients are.

Emergency Use: If an emergency exists, and providing you with this notice is not practice, we may use or disclose Protected Information to the extent necessary during the emergency.

Notification: Unless you have informed us otherwise, your Protected Information may be used or disclosed by us to notify or assist in notifying you, a family member, relative or other person who is involved in your care to the extend necessary for them to participate in your care.

Communication with Family Members and Caregivers: With your permission or by court or agency order, we will release Protected Information to a family member, relative or other person who is involved in you care to the extent necessary for them to participate in your care.

Marketing and Fundraising Activities: We may use your Protected Information for the purpose of contacting you regarding benefits and services we feel may be of interest to you. In addition, you may also be contacted as a part of a fund-raining effort. You may decline to receive information of this type.

Research Purposes: In some instances, your Protected Information may be used or disclosed for research purposes. All research projects which use Protected Information are subject to a special approval process which will, among other things, evaluate the precautions used to protect medical information. In some cases, information which identifies you as receiving services will be removed.

Special Circumstances: The law specifically requires us to disclose Protected Information in the following special circumstances:

Public Health Activities: We are required to use or disclose your Protected Information for public health activities and purposes. Examples of public health activities which would warrant the use or disclosure of your Protected Information include:
1. Preventing or controlling disease, injury, or disability;
2. Reporting births or deaths;
3. Reporting the abuse or neglect of a child or dependent adult;
4. Reporting reactions to medications or problems with products; or
5. Notifying individuals exploded to a disease who may be at risk for contracting or spreading the disease.

Specialized Government Functions: Your Protected Information may be used or disclosed for a variety of government functions subject to some limitations. These government functions include:
Military and veterans' activities;
National security and intelligence activities;
Protective service of the President and others;
Medical suitability determinations for Department of State officials;
Correctional institutions and law enforcement custodial situations; or
Provision of public benefits.

Important Contact Information: This notice has been provided to you as a summary of how we will use your Protected Information and your rights with respect to your Protected Information. If you have any questions or for more information regarding your Protected Information, please contact the Chief Information Officer.

If you believe your privacy rights have been violated, you may file a complaint with our office by contacting Lance Roorda or Shanon Claussen. You may also file a complaint with the Secretary of Health and Human Services by internet access at www.hhs.gov. There will be no retaliation for the filing of a complaint.

Effective Date and Revisions: This notice becomes effective on April 1st, 2019. Please note, we reserve the right to revise this notice at any time. Should we raise the notice; the revised notice will be posted at the local office. In addition, a current copy of our notice of privacy practices may be obtained from an Eunoia Counseling employee.

When applicable, Eunoia Counseling may need to exchange information with DHS staff or other groups who work with DHS. Part of this exchange includes sending information with the DHS staff or other groups who also work with DHS. Part of this exchange may include sending DHS quarterly/progress reports and summary letters upon termination of our services with your family. We will obtain a release of information to exchange this information when/if applicable.

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Client Name: ________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I _________________________________, hereby acknowledge I have been given an opportunity to read a copy of Eunoia Counseling Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can discuss with my provider. I am aware that this notice educates me on the way my identifiable health information may be used or disclosed. I understand that this notice also informs me of my rights regarding my protected information.

____ __________________
Signature of Client/Legal Representative Date

____
Relationship to Client

____ __________________
Witness Date

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Client Name: ______________________

Primary Physician Information

Primary Physician: ________________________________ Specialty: _____________

Address: ____ Phone #: _________ -_____

_________ Please **SEND** diagnostic information to my primary physician

_________ Please **DO NOT** send diagnostic information to my primary physician

_________ I DO NOT have a primary physician, please **DO NOT** send diagnostic information

I understand that Eunoia Counseling, my health plan representative, and my primary care physician may exchange any and all information pertaining to my services to the extent such dis closure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan. Part of this exchange includes sending treatment plans, quarterly/progress reports, and summary letters upon termination of our services with your family.

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Client Name: ______________________

Acknowledgement of Receipt of Initial Intake Packet

I hereby acknowledge I have been given an opportunity to read a copy of Eunoia Counseling Service Initial Intake Information. I understand that I can request a copy of the intake packet should I want one. This intake packet includes information regarding:

- An explanation of services
- Client rights and responsibilities
- Grievance procedure
- Abuse reporting policy
- Records
- Termination
- Managed Care Limitations
- Emergencies

I have read and understand the Initial Intake Information and agree to comply with the policies and procedures. I have had the opportunity to ask questions regarding the policies and procedures.

______________________________________ ______________________________
Patient (if over age 18) or Parent/Guardian Signature Date

______________________________________ ______________________________
Relationship /Printed Name Witness Signature

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Client Name: ______________________

Appointment Reminders

_______ I wish to receive email appointment reminders

Email address: ____

_______ I wish to receive text message appointment reminders

Cell Phone Number: _______________________________________

Cell Phone Carrier (Verizon, AT&T, US Cellular, etc.) _______________________

____ _____________
Signature of Client/Legal Representative Date

____
Relationship to Client