**Adult Client Intake**

**General Information:**

Name of Client: Date of Birth:

Gender: Ethnicity: Religion:

Street:

City, State, Zip Code:

Home Phone: Cell: Other:

On what phone number may we leave a confidential message? 🞎 Home 🞎Cell 🞎Other

Would you like to receive appointment reminders? 🞎 Text 🞎 Email 🞎 Phone 🞎 No Thank you

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment/School Information:**

Please Circle All That Apply: Employed Self Employed Disabled Retired Unemployed Military Homemaker Student

High School/GED Some College College Degree:

What type of grades did/do you make in school? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Did you have a(n) 🞎 IEP or 🞎 504? 🞎N/A

Were you ever 🞎Suspended 🞎Truant 🞎Expelled 🞎N/A

Name of Employer/School: Occupation: How Long?

How do you feel about your current job? 🞎Love It 🞎Hate It 🞎Put Up with It

Annual Income: How many in your household:

**Social History:**

*Family Information:*

Are your parents: Legally married or living together? 🞎 Yes 🞎 No Mother remarried: \_\_\_\_\_ number of times

Temporarily separated? 🞎 Yes 🞎 No Father remarried: \_\_\_\_\_ number of times

Divorced or permanently separated? 🞎 Yes 🞎 No Your age when divorced/separated

Mother: 🞎Living 🞎Deceased Father: 🞎Living 🞎Deceased

Do either of your parents have a history of trauma/abuse? 🞎 Yes 🞎 No Substance Abuse? 🞎 Yes 🞎 No

Please briefly describe your relationship with your parents:

Siblings? (please include ages, gender, and if step):

Describe your Marital Status: 🞎Married 🞎Divorced 🞎Separated 🞎Single 🞎Cohabitating w/ Partner

Were you adopted? 🞎 Yes 🞎 No Were you ever in Foster Care? 🞎 Yes 🞎 No Were you ever involved with DHS? 🞎 Yes 🞎 No

With whom do you reside? 🞎Spouse/Partner 🞎Parents 🞎Children 🞎Roommate 🞎Friends 🞎Alone 🞎Other

Do you have Children? (Please List Ages):

Please describe your support system(s), i.e. friends, family, pets, etc….

How would you generally describe your relationships? 🞎Stable 🞎Conflicted 🞎Long-term 🞎Fleeting 🞎Co-Dependent

**Strengths/Interests:**

What do you like most about yourself?

What do others admire about you?

Hobbies/Interests:

**Presenting Problem:**

Why are you here today?

How would you rate the severity of your problem? 🞎 Low 🞎 Moderate 🞎 Severe 🞎 Very Severe

How long has this been a problem? 🞎 Less than one year 🞎Longer than one year

Have you ever been diagnosed with a mental health disorder? 🞎 Yes 🞎 No Diagnosis:

Check current or past treatments 🞎 EAP 🞎 Counseling 🞎 Psychiatric Medications 🞎 Psychiatric Hospitalizations

What would you like to accomplish/address in therapy?

**Are any of the following a current or past issue?**

Domestic Violence? 🞎 Current 🞎 Past 🞎 None Sexual Abuse? 🞎 Current 🞎 Past 🞎 None

Child Abuse? 🞎 Current 🞎 Past 🞎 None Sexual Assault? 🞎 Current 🞎 Past 🞎 None

Child Neglect? 🞎 Current 🞎 Past 🞎 None Trauma? 🞎 Current 🞎 Past 🞎 None

Suicidal Thoughts ? 🞎 Current 🞎 Past 🞎 None Homicidal Thoughts? 🞎 Current 🞎 Past 🞎 None

Suicide Attempts? 🞎 Current 🞎 Past 🞎 None Self Mutilation/Cutting? 🞎 Current 🞎 Past 🞎 None

Legal Issues? 🞎 Current 🞎 Past 🞎 None Arrests? 🞎 Current 🞎 Past 🞎 None

Please briefly describe sections marked current or past above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

**Health/Medical Information:**

Primary Care Physician (PCP): PCP Phone:

Private and government insurance requires us to coordinate care with your PCP. Do you consent to discuss your care with the PCP listed above? 🞎 Yes 🞎 No Signature

When was your last physical/doctor visit and what was it for?

Allergies: Are you allergic to dogs? 🞎 Yes 🞎 No

Medications (Name, Dose, Frequency):

Chronic Health Conditions/Past Surgeries/Hospitalizations:

Family Medical History: Is there any family history of chronic illness? If so, please describe who (mom, dad, sibling, grandparent) and what the condition is/was.

Family Mental Health History: Is there any family history of mental illness? If so, please describe who (mom, dad, sibling, grandparent) and what the condition is/was.

**Symptoms (Check those which you have experienced in the last month):**

🞎Difficulty Falling Asleep 🞎Difficulty Staying Asleep 🞎Difficulty Getting Up

🞎Not feeling rested 🞎Nightmares 🞎Average Hours of Sleep per Night:

🞎Changes in eating/appetite 🞎Eating more 🞎Eating less 🞎Binge eating

🞎Are you trying to lose weight? 🞎Weight gain: lbs 🞎Weight loss: lbs

🞎Voluntary vomiting 🞎Use of laxatives 🞎Excessive exercise to avoid weight gain

🞎Back Pain 🞎Stomach Aches 🞎Headaches 🞎Chest Pain

🞎Tremors 🞎Increased Energy 🞎Decreased Energy 🞎Hyperactivity

🞎Depressed Mood 🞎Rapid mood changes 🞎Irritability 🞎Guilt

🞎Anxiety 🞎Panic attacks 🞎Outbursts of anger 🞎Frequent worry

🞎Grief/Loss 🞎Phobias 🞎Hear voices 🞎Obsessions

🞎Delusions 🞎Hallucinations 🞎Intrusive Thoughts 🞎Hypervigilance

🞎Hopelessness 🞎 🞎 🞎

**Substance Use:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Please include past and present | How Long? | How Much?  How Often? | Age of 1st Use | Is it causing a problem?  If so, what type? |
| Tobacco | 🞎 Yes 🞎 No |  |  |  |  |
| Drugs | 🞎 Yes 🞎 No |  |  |  |  |
| Alcohol | 🞎 Yes 🞎 No |  |  |  |  |
| Have you ever felt that you should cut down on your drinking or drug use? 🞎 Yes 🞎 No | | | | | |
| Have people annoyed you by criticizing your drinking or drug use? 🞎 Yes 🞎 No | | | | | |
| Have you ever felt bad or guilty about your drinking or drug use? 🞎 Yes 🞎 No | | | | | |
| Have you ever had a drink or used drugs first thing in the morning to steady your nerves to get rid of a hangover? 🞎 Yes 🞎 No | | | | | |

**Dear Client,**

**We are so happy you decided to come to us! We value all our clients and want to make sure we do everything we can to preserve the therapeutic relationship. This relationship will be the basis for healing and growth. Here are a few things to consider to preserve the relationship:**

**Attendance**

* Please make every effort to keep your appointments. It is our ultimate goal to provide you with the treatment and support you need to be your best self. Therapy gains momentum and disruptions may impair the healing process. Remember, we cannot help you or your child if you are not here.
* An appointment is considered missed if less than 24-hour notice is given to cancel the appointment. No call/no show will be considered a missed appointment.
* If you are going to be more than 15 minutes late the appointment will need to be rescheduled and will be considered a missed appointment.

**Payment/Scheduling/Missed Appointments/Fees**

* Payment is due at the time of service and is accepted in the form of cash, credit, or debit. You may sign a release to allow storage of your credit card information in our secure system to be charged on the day of your scheduled session. You can also make payments on our patient portal prior to the appointment.
* Missed appointments are discouraged and will put you at risk for losing your time slot and/or being discharged. Due to the high demand for evening and weekend appointments you will be allotted 1 missed appointment during these times before having to move to a weekday appointment.
* Missed appointments will be charged a fee equal to the regular session fee. Missed appointment fees must be paid prior to next appointment. Medicaid clients will not be assessed the missed session fees due to contract regulations.
* If you miss more than 3 sessions per calendar year you will be discharged until such time you can remove barriers to attendance.

**Costs not covered by insurance**

* In most cases insurance companies will not provide compensation for writing letters, completing paperwork, or phone calls. If you are requesting one of these services on you or your child’s behalf, you will be charged $25.00 for each 15 minutes, with a minimum of 30 minutes charged. Therapist will provide an estimate of how long the task will take and payment is expected prior to the therapist beginning the letter or report. The same fee applies for phone consultations or collateral contacts more than 15 minute in length.
* Court fees are not covered by insurance and will need to be paid in advance.
* Missed appointment fees are not covered by insurance.

**Confidentiality/Mandatory Reporter**

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse, danger to self, danger to others, and elder abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

* Communications including email and text are not encrypted so confidentiality using these means of communication can not be guaranteed to remain confidential. Be Well recommends keeping these to a minimum and not using to share confidential information.
* Be Well Counseling Services follows guidelines set by the Health Insurance Portability and Accountability Act (HIPPA). A copy of these guidelines is included in the intake packet and available on our website.
* Be Well Counseling Services contributes to the continuation of the field of counseling psychology by training counseling students, interns, Registered Psychotherapists, and Licensed Professional Counselor Candidates in preparation for professional practice. Therapists in training are advanced graduate students receiving intensive training and on-going supervision from a Licensed Professional Counselor. As a training facility, Be Well Counseling Services requires sessions with clients be recorded. The director, supervisors, staff, and interns may view recorded sessions only for training and supervision purposes. All persons authorized to view counseling sessions are legally bound to maintain confidentiality of the material discussed and to protect your identity.

**Client Initials \_\_\_\_\_\_\_\_\_\_ BW Initials \_\_\_\_\_\_\_\_\_\_**

**Retention of Records**

* Records are retained for a period of seven years, commencing on either the termination of professional counseling services or the date of last contact with the client, whichever is later. When the client is a child, the record shall be retained for a period of seven years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

**Minors**

* To ensure a therapeutic, trusting relationship therapists will not reveal specifics regarding what occurred during the session. Therapists will report overall themes and provide suggestions to parents to support minors in the healing process.
* In the state of Colorado minors age 12 or over consent for their own psychological treatment. What this means for the parent/guardian is the minor must sign a release for the therapist to speak with the parent and sign Be Well intake forms. Minors over the age of 12 have a say in what, if anything, is disclosed to parents/guardians.
* If legal custody is held by a county Department of Human Services, it will be determined who holds legal “privilege” for children age 11 or less. Legal “privilege” may only be held by a parent, legal guardian, Guardian Ad Litem, or the client depending on age and ability to make sound decisions.
* Parents must remain on the premises while children are in sessions in case of an emergency or the need for parental support.
* Children under the age of 12 are not to be left unsupervised in the waiting areas.

**Legal Testimony/Subpoena’s**

* Therapist will not testify or provide recommendations (written or otherwise) for custody or placement of children. Testimony that can cause damage to the therapeutic relationship will not be provided unless ordered by a judge.
* In the event the therapist is subpoenaed information shared can only be released if therapist has a signed release of information from whomever holds legal privilege. Fees must be paid in advance.

**Weather**

* Due to the unpredictable nature of Colorado weather we want to ensure the safety of clients and employees during inclement weather. If you do not feel safe driving please contact our office at 719-302-3175 for alternative options including, videoconferencing, phone calls, or rescheduling. The options may vary depending on your insurance provider.

**Illness**

* If you have experienced a fever in the last 24 hours or believe you may have a contagious illness, please contact our office. Alternative options including, videoconferencing or rescheduling may be available depending on your insurance provider.

**Emergency Procedures**

* If you are having a mental health emergency, you may try to contact your therapist. In the event of a life- threatening emergency please go to the nearest emergency room or call 911. Please do not wait for therapist to return call if you are in a life-threatening emergency.

**Client Initials \_\_\_\_\_\_\_\_\_\_ BW Initials \_\_\_\_\_\_\_\_\_\_**

**Disclosure Statement**

|  |  |
| --- | --- |
| **Therapist:** | **Degree:** |
| **License:** | **Phone:** |
| **Clinical Supervisor:** Christine Ault, MS, LPC, RPT-S | **Degree: Master of Science in Community Counseling** |
| **License:** Licensed Professional Counselor (LPC.012925) | **Phone:** 719-302-3175 x 701 |

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Department of Regulatory Agencies (DORA) can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

As to the regulatory requirements applicable to mental health professionals:

* Certified Addiction Counselor III (CAC III) must have a bachelor’s degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
* Licensed Addiction Counselor must have a clinical master’s degree and meet the CAC III requirements.
* Licensed Social Worker must hold a master’s degree in social work.
* Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
* A Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and Licensed Professional Counselor must hold a master’s degree in their profession and have 2 years of post-master’s supervision.
* A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

I have read and agree to all terms in this document and consent to services with Be Well Counseling Services.

Print Client Name Date of Birth

Client Signature Date Signed

Print Client Name Date of Birth

Client Signature Date Signed

Be Well Counseling Services Representative Signature Date Signed

**If the person signing is not the client, please complete the section below**

Print Responsible Party Name Relationship to Client

Responsible Party’s Signature Date Signed

Print Responsible Party Name Relationship to Client

Responsible Party’s Signature Date Signed

**Authorization for Use or Disclosure of Medical Information**

Name of Client: Date of Birth:

I hereby authorize Be Well Counseling Services, its agents or affiliates to disclose the protected health information (PHI) indicated below to the persons or entities specified on this form.

List those who you are authorizing to use or receive your information. Please include Name, Address, Phone:

1. Physician:
2. Psychiatrist:
3. Insurance:
4. School District:
5. Other:
6. Other:
7. Emergency Contact:
8. Guardian Ad Litem:
9. El Paso County Department of Human Services

Information to be Disclosed: 🞏 Entire Record 🞏Other

My authorization includes the release of the following (Please initial on line and answer yes or no):

🞏 Yes 🞏 No Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency

🞏 Yes 🞏 No Diagnosis and/or treatment of mental illness

🞏 Yes 🞏 No HIV antibody test results and/or AIDS diagnosis and treatment

Purpose of Information to be Disclosed: 🞏Treatment 🞏Coordination of Care 🞏Billing/Claims

🞏 Other

Expiration/Revocation:

This form will remain effective for up to 6 months after client discharges from therapy. Client or client’s responsible party may request to revoke this form at any time.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Client or Responsible Party’s Signature Relationship to Client Date

Client or Responsible Party’s Signature Relationship to Client Date

**Insurance & Financial Policy**

Client Name: DOB:

**Employment & Insurance Information:**

*Primary Insurance:*

Insurance Provider:  Subscriber Date of Birth:

Subscriber Name: Subscriber SSN:

Policy ID #:  Group #: Subscriber’s Employer:  Work Phone:

*Secondary Insurance:*

Insurance Provider:  Subscriber Date of Birth:

Subscriber Name: Subscriber SSN:

Policy ID #:  Group #: Subscriber’s Employer:  Work Phone:

**Financial Responsibility and Consent:**

* Payment is due at the time of service and is accepted in the form of cash, credit, or debit. You may sign an authorization to allow storage of your credit card information in our secure system to be charged on the day of your scheduled session.
* Missed appointments will be charged a fee equal to the regular session fee or 60.00, whichever is less, and must be paid prior to next appointment.
* An appointment is considered missed if client fails to show up for scheduled session or less than 24 hours notice is given to cancel the appointment. You may cancel using our automated system, client portal, or by contacting your therapist directly.
* If you are going to be more than 15 minutes late the appointment will need to be rescheduled and will be considered a missed appointment subject to missed appointment fees.
* If the cost of treatment exceeds benefits from your insurance company, to the full extent contractually allowed, you understand and agree that you are responsible for full and timely payment.
* The responsible party agrees to inform therapist of any coverage and/or benefit changes as quickly as possible. Responsible party will be liable and responsible for direct payment to Be Well Counseling Services of any and all denied claim amount(s).
* This consent shall remain in effect until all outstanding balances have been paid in full.

I hereby authorize Be Well Counseling Services to provide summary of care and assessment information regarding evaluation and/or treatment of client for the purpose of evaluating and processing claims for benefits.

Print Responsible Party’s Name Date

Responsible Party’s Signature Relationship to Client

**Authorization for Credit Card Use**

PRINT AND COMPLETE AUTHORIZATION AND RETURN.

All information will remain confidential

**(Not Required for Medicaid)**

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Co-Pay/Charge Amt: \_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Type: \_\_ Visa \_\_ Mastercard \_\_ Discover \_\_ AmEx

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Card Identification Number: \_\_\_\_\_\_ (3-4 digits located on the back of the credit card)

The amount charged may represent scheduled or periodic charges for one or more of these payment purposes (effective as of the date signed):

Regular recurring appointment charges (weekly; bi-weekly; monthly)

Missed appointment charges

**AUTHORIZATION**

I hereby authorize Be Well Counseling Services, Inc., to charge the indicated credit card for any/all fees associated with counseling/therapy appointments for myself and/or my family member(s). I agree that the charge will be applied to my credit card according to my Be Well appointment schedule, and in order to cancel the recurring billing process, I am required to contact Be Well one (1) month in advance to either cancel the associated Be Well account or arrange for an alternative method of payment. I agree that if I have any problems or questions regarding my account or any services provided by Be Well, I will contact Be Well for assistance using the contact information on their website at www.bewellcs.com. I also agree that I will not dispute any charges with my credit card company without first making a good faith effort to remedy the situation directly with Be Well. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this recurring credit card billing agreement with Be Well.

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

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

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY RIGHTS**

THIS NOTICE DESCRIBES HOW MEDICAL [INCLUDING MENTAL HEALTH] INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. During the process of providing services to you, Be Well Counseling Services will obtain, record, and use mental health and medical information about you that is protected health information. Ordinarily that information is confidential and will not be used or disclosed, except as described below.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. General Uses and Disclosures Not Requiring the Client’s Consent. The Center will use and disclose protected health information in the following ways.

1. Treatment. Treatment refers to the provision, coordination, or management of health care [including mental health care] and related services by one or more health care providers. For example, Center staff involved with your care may use your information to plan your course of treatment and consult with other staff to ensure the most appropriate methods are being used to assist you.

2. Payment. Payment refers to the activities undertaken by a health care provider [including a mental health provider] to obtain or provide reimbursement for the provision of health care. For example, the Center will use your information to develop accounts receivable information, bill you, and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payors may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment. If you are covered by Medicaid, information will be provided to the State of Colorado's Medicaid program, including but not limited to your treatment, condition, diagnosis, and services received.

3. Health Care Operations. Health Care Operations refers to activities undertaken by the Center that are regular functions of management and administrative activities. For example, the Center may use your health information in monitoring of service quality, staff training and evaluation, medical reviews, legal services, auditing functions, compliance programs, business planning, and accreditation, certification, licensing and credentialing activities.

4. Contacting the Client. The Center may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

5. Required by Law. The Center will disclose protected health information when required by law or necessary for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when required to report certain communicable diseases and certain injuries; and (f) when a Coroner is investigating the client’s death.

6. Health Oversight Activities. The Center will disclose protected health information to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, regulatory programs or determining compliance with program standards.

7. Crimes on the premises or observed by Center personnel. Crimes that are observed by Center staff, that are directed toward staff, or occur on the Center’s premises will be reported to law enforcement.

8. Business Associates. Some of the functions of the Center are provided by contracts with business associates. For example, some administrative, clinical, quality assurance, billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

9. Research. The Center may use or disclose protected health information for research purposes if the relevant limitations of the Federal HIPAA Privacy Regulation are followed. 45 CFR § 164.512(i).

10. Involuntary Clients. Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

11. Family Members. Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client’s consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if the client objects, protected health information will not be disclosed.

12. Fund Raising. The Center, or its institutionally related fund raising Foundation, may contact clients as a part of its fund raising activities. PHI will be used and disclosed for fundraising communications if Be Well Counseling Services contacts you to raise funds for the organization. However, you have a right to opt out of receiving such communications.

13. Emergencies. In life threatening emergencies Center staff will disclose information necessary to avoid serious harm or death.

B. Client Release of Information or Authorization. The Center may not use or disclose protected health information in any other way without a signed release of information or authorization. When you sign a release of information, or an authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent the Center has already taken action in reliance thereon.

C. Uses and disclosures of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, require authorization from you.

II. YOUR RIGHTS AS A CLIENT

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the protected health information the Center has regarding you, in the designated record set. You can obtain it in paper or electronically. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask Center staff for the appropriate request form.

B. Amendment of Your Record. You have the right to request that the Center amend your protected health information. The Center is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. To make a request, ask Center staff for the appropriate request form.

C. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures the Center has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask Center staff for the appropriate request form.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. The Center does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. To make a request, ask Center staff for the appropriate request form.

E. Alternative Means of Receiving Confidential Communications. You have the right to request that you receive communications of protected health information from the Center by alternative means or at alternative locations. For example, if you do not want the Center to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Center staff for the appropriate request form.

F. Restricting Disclosures. You have a right to restrict certain disclosures of PHI to a health plan where you pay out of pocket in full for the health care service. Upon your request, Be Well Counseling Services must agree to a restriction on the disclosure of PHI to a health plan if: (1) the disclosure of PHI would be for the purposes of carrying out payment or health care operations, and is not otherwise required by law; and (2) the PHI pertains solely to a health care service for which you, or a person acting on your behalf, has paid Be Well Counseling Services in full.

G. Breaches. You have a right to be notified following a breach of unsecured PHI.

H. Psychotherapy Notes. If your provider keeps psychotherapy notes (informational notes about your care that is separate from the official clinical record), uses and disclosures of theses psychotherapy notes require authorization from you.

I. Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

III. ADDITIONAL INFORMATION

A. Privacy Laws. The Center is required by State and Federal law to maintain the privacy of protected health information. In addition, the Center is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. The Center is required to abide by the terms of this Notice, or any amended Notice that may follow. The Center reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. When the Notice is revised, the revised Notice will be posted in the Center’s service delivery sites and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe the Center has violated your privacy rights, you have the right to complain to Center management. To file your complaint, call the privacy officer at 719302-3175. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202. It is the policy of the Center that there will be no retaliation for your filing of such complaints.

D. Additional Information. If you desire additional information about your privacy rights at the Center, please call 719-302-3175 and ask to speak to the privacy officer.

IV. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

A. The confidentiality of alcohol and drug abuse patient records maintained by this center is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

1. The patient consents in writing:

2. The disclosure is allowed by a court order; or

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

B. Violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

C. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

D. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations).

E. Effective Date. This Notice is effective May 1, 2016.

**Receipt of Privacy Rights**

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

I acknowledge that I have received a copy of the Center’s Notice of Privacy Rights.

Print Client’s Name Date

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

Intake Clinician:

If client denies or refuses to accept notice of privacy rights or sign this acknowledgement, please document reason below.

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

Clinician Signature Date

**Adverse Childhood Experience (ACE) Questionnaire**

**Finding your ACE Score** ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other? Yes No If yes enter 1 \_\_\_\_\_\_\_\_

5. Did you often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

6. Were your parents ever separated or divorced? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No If yes enter 1 \_\_\_\_\_\_\_\_

9. Was a household member depressed or mentally ill or did a household member attempt suicide? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

10. Did a household member go to prison? Yes No

If yes enter 1 \_\_\_\_\_\_\_\_

**Now add up your “Yes” answers: \_\_\_\_\_\_\_ This is your ACE Score**