


The Center for Counseling

*Your Life Is Precious.*SM

Cancellation Policy

The therapists and physicians have a waiting list to see patients, due to this fact we must insist that you give us at least a 24 hour notice if in fact you need to cancel or reschedule an appointment. This allows us to try and fill the spot with a client that may be on our waiting list.

You may also leave a message on our voice mail if you must cancel an appointment over the weekend or a holiday.

If we do not receive ample notification *prior* to your appointment, you will be charged \$45.

I acknowledge my financial responsibility if I do not comply with The Center for Counseling's Cancellation Policy.

Signature client/guardian

Date

Clinician

Date

CLIENT'S BILL OF RIGHTS

*Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.

*Each client has the right to be free from neglect, exploitation; and verbal, mental, physical and sexual abuse.

*Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.

*Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.

*Each client has the right to be informed of the nature and purpose of any services rendered and the name and title of personnel providing that service.

*There are circumstances that would allow for exceptions to obtaining informed consent such as: situations involving threat of harm to self or others, child or elder abuse. Under these circumstances information about the individual served must be disclosed or reported.

*Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.

*It is the right of each client to receive individualized treatment which includes:

*Adequate and humane services regardless of the source of financial support.

*Services provided in the least restrictive environment possible.

*An individualized treatment plan which is reviewed periodically and as needed.

*To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.

*If at anytime during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency:

They have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.

*The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.

*The client will be informed of his/her rights in a language they can understand.

*Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.

*Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

***Recipients have rights protected by state and federal law and promulgated rules. For Information contact:**

Office Manager

32743 23 Mile Road, Suite 130

New Baltimore, MI 48047

The above Bill of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

Client/Guardian Signature

Date

Consent for Treatment Anger Management Education

1. I voluntarily consent to participate in the eight-week anger management education series.
2. I have been given the opportunity for discussion of any concerns that I have regarding the series.
3. I understand:
 - A. That I may withdraw my consent at any time.
 - B. My financial responsibility a \$45 **registration fee** which will be applied to final group session, \$45 **per group**.
 - C. That if I miss an education date, I know that I need to make up that date in the next series or be discharged for non-compliance.
 - D. That I will be charged \$25.00 for any non-sufficient fund checks.
 - E. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.
 - F. If a minimum of 24-hour notice for cancellations is not given I will be charged at the education series date rate. **NO EXCEPTIONS!**
 - G. A release of information will have to be signed and payment in full prior to reports being released to court.
 - H. That if my therapist or physician must write letters or fill out insurance forms there will be a \$75 charge for this service and that it takes up to a week to complete.
4. I have read and received a copy of the fire evacuation/fire drill procedure. Tornado warning drill procedure, building map.
5. It will be the policy of The Center for Counseling to formally charge a fee for phone calls either before or after business hours. This fee will need to be paid before your next session. The fees are up to 30 minutes = \$45.00, 31-60 minutes = \$90.00, after 61 minutes, the charge will be \$1.00 per additional minute.

Student's Signature/Date

Staff Signature/Date

PERSONAL HISTORY FORM

- MENTAL HEALTH SUBSTANCE ABUSE

FORM COMPLETED BY (If someone other than client) _____

A) What brought you into treatment: _____

B) What are your expectations for treatment _____

C) Prior treatment experiences (Dates and Location _____

D) Name of Primary Care Physician _____ Phone _____

E) Current Living Arrangements:

1. House Group Living Apartment Other (Specify) _____
 2. Alone With Family Unrelated Significant Other

I. CLIENT INFORMATION (past and present)

1) Treatment Experiences Yes No Inpat./Outpt/ IOP When Where

	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2) Presenting Problem (Check all boxes that apply)

- | | |
|--|--|
| <input type="checkbox"/> Medical/Organic condition | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Aggressive Behavior |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Suicidal Ideation's |
| <input type="checkbox"/> Chemical Abuse/Dependency | <input type="checkbox"/> Self-destructive Behavior |
| <input type="checkbox"/> Delusions/Hallucinations | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Family Issues | <input type="checkbox"/> Life Decision |
| <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Uncertain |
| <input type="checkbox"/> Other (please elaborate) | |

3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity Level	<input type="checkbox"/>	<input type="checkbox"/>
Eating Patterns	<input type="checkbox"/>	<input type="checkbox"/>	General Disposition	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Weight	<input type="checkbox"/>	<input type="checkbox"/>
Energy	<input type="checkbox"/>	<input type="checkbox"/>	Increased tension	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please describe

Are you in physical pain yes no if yes where/what kind

If yes please rate pain _____ 0=none 5=mild(tolerable) 10=severe(referral)

THERAPY IMPLICATIONS:

II. **INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS;** past and present

1. **Family Constellation**

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
			YES	NO	YES	NO
Client						
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives) <i>Specify Relationship</i>						

2) FAMILY/EXTENDED FAMILY HISTORY

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3) Family History

1. What City/State were you born? _____
2. Where did you grow-up? _____
3. Who raised you as a child? _____

4) Parental Information

- Parents legally married
- Mother remarried (number of times)
- Parents ever separated
- Father remarried (number of times) _____
- Parents ever divorced

Describe relationships with parents, step-parents

1. As a child _____

2. Currently _____

5) SIBLING INFORMATION

Number of living siblings/step siblings _____ Number of deceased siblings/step-siblings _____

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe relationships with siblings:

1. As a child _____
2. Currently _____

- Family will be involved in treatment
- Family uninvolved

Why/Why Not: _____

6) **Marital Information**

- Single Unmarried and living with significant other. Length of time _____
 - Legally married: Length of time: _____ Total number of marriages: _____
 - Separated: Length of time _____ Divorce in process: Yes No
 - Divorced: Length of time _____ Widowed: Length of time _____
- Are there problems in this relationship (check all that apply)
- Money Chemical Dependency
 - Sexual Mental illness
 - Physical Abuse Religion
 - Child rearing/discipline issues Other

THERAPY IMPLICATIONS: _____

III. **SOCIAL INFORMATION**

1) **Support System** (check all that apply)

- Adequate social support Recent move / relocation Conflict with peers
- Transportation problems Lack of knowledge of resources Isolative
- Problems establishing / maintaining relationships

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups) _____

THERAPY IMPLICATIONS: _____

2) **Sexuality**

- What is your sexual preference Male Female Both Uncertain
- Have you been tested for HIV Yes No
- Are there sexual issues that you would like to discuss with your therapist? Yes No
- Have you ever been sexually and/or physically abused? Yes No

THERPAY IMPLICATIONS: _____

3) **Interests/Hobbies**

- | | |
|--------------|------------------------|
| Art _____ | Book/Films _____ |
| Music _____ | Physical Fitness _____ |
| Crafts _____ | Outdoor Activity _____ |
| Sports _____ | Diet/Health _____ |

Current Memberships (church , clubs, organizations)
Do you participate in any cultural activities related to your ethnic background? Yes No

THERAPY IMPLICATIONS: _____

4) **Spirituality**

- Do you believe in a god or a power greater than yourself? Yes No
- What religion were you raised? _____
- What religion are you currently affiliated? _____
- At this point in your life, what is most important to you? _____

THERAPY IMPLICATIONS: _____

IV. **EDUCATION** (check all that apply)

- High school diploma (GED) Currently enrolled: Last grade completed _____
- Did not complete high school: last grade completed _____
- Vocational training: Training completed, type _____ Currently enrolled
- College: Degree earned, type _____ Currently enrolled/# of years completed _____
- Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.)

THERAPY IMPLICATIONS: _____

V. **EMPLOYMENT/VOCATIONAL** (Beginning with most recent job, give employment history, include homemaker experience)

Employer	Dates	Job Description	Salary

THERAPY IMPLICATIONS: _____

VI. **MILITARY**

Branch _____
Date drafted/enlisted _____
Combat experience Yes No
Where _____

Type of Discharge _____
Rank at Discharge _____
Date of Discharge _____ Where _____

THERAPY IMPLICATIONS: _____

VII. **LEGAL DATA**

Are you presently on probation or parole: Yes No

If yes reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): Yes No

If yes, please describe and indicate the court hearing/trial date _____

Past History (adolescent and adult)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Traffic Violations
<input type="checkbox"/>	<input type="checkbox"/>	Civil Involvement
<input type="checkbox"/>	<input type="checkbox"/>	Criminal Involvement

If yes to any of the above, please complete the following

Charges	Date	Where	Results

THERAPY IMPLICATIONS: _____

VIII **Nutritional Assessment**

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION	Yes	No
Do you have an illness/condition that made you change the type/amount of food you eat?	Yes=2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	Yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	No
Do you always have enough money to buy the food you need?	Yes	No=4
Do you eat alone most of the time?	Yes=1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

TOTAL SCORE _____

0-2= Low Risk 3-5= Moderate Risk 6-21= High Risk* *Referral

THERAPY IMPLICATIONS:

IX TRAUMA

Any history of trauma, abuse, neglect or exploitation? No Yes

If yes: When and type _____

THERAPY IMPLICATIONS:

X Alcohol/Substance Use

Substance preferred _____

Date of last drink _____ / Date of last drug use _____

Type and amount of drink at last episode Beer _____ oz Wine _____ oz Liquor _____ oz

Age drinking/ drug use began _____

Type of alcohol preferred: Beer Wine Liquor

How often do you drink/use drugs? Daily Weekly Monthly Other _____

Have you ever had any legal problems related to your use of alcohol/drugs? Yes No

Have you ever had any relationship problems related to your use of alcohol/drugs? Yes No

*****Has drinking or drug use ever become a problem? Yes No**

*****If YES, please complete next page. (Substance Abuse Addendum)**

If NO go to page 10

THERAPY IMPLICATIONS: _____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS:

ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST

Please check all that apply.

PHYSICAL	EMOTIONAL	BEHAVIORAL
<input type="checkbox"/> Blackouts <input type="checkbox"/> Memory Problems <input type="checkbox"/> Tremors/ Shakes <input type="checkbox"/> Seizures <input type="checkbox"/> DT=s <input type="checkbox"/> Hallucinations <input type="checkbox"/> Overdose <input type="checkbox"/> Appetite Problems <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Injury <input type="checkbox"/> Accidents <input type="checkbox"/> Other Medical Problems <input type="checkbox"/> Other	<input type="checkbox"/> Depression <input type="checkbox"/> Confusion <input type="checkbox"/> Concentration Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability / Restlessness <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Mood Swings <input type="checkbox"/> Impulsivity <input type="checkbox"/> Euphoria <input type="checkbox"/> Relaxation <input type="checkbox"/> Extreme Jealousy <input type="checkbox"/> Paranoia <input type="checkbox"/> Feelings of Guilt/ Shame <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Other	<input type="checkbox"/> A.M. Use <input type="checkbox"/> Sneaking <input type="checkbox"/> Gulping <input type="checkbox"/> Loss of Control <input type="checkbox"/> Relief Use <input type="checkbox"/> Impulsive Use <input type="checkbox"/> Use less than before <input type="checkbox"/> Use more than before <input type="checkbox"/> Use despite negative Consequences <input type="checkbox"/> Associate with using friends <input type="checkbox"/> Plan activities around use <input type="checkbox"/> Loss of interest in activities <input type="checkbox"/> Change in work/school performance <input type="checkbox"/> Work/school lateness/ absenteeism <input type="checkbox"/> Job loss due to use <input type="checkbox"/> Frequent arguments <input type="checkbox"/> Separation/divorce <input type="checkbox"/> Financial problems <input type="checkbox"/> Legal problems <input type="checkbox"/> Physically abusive to self <input type="checkbox"/> Physically abusive to others <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Homicide attempts <input type="checkbox"/> Other

If any of the above are checked off, please describe: _____

III. SUBSTANCE ABUSE FAMILY HISTORY

Please describe the alcohol/drug problems of others in your family, past and present. Also describe treatment and recovery experience.

WHO/RELATIONSHIP	PROBLEM TYPE	TREATMENT/RECOVERY

XI. MEDICAL INFORMATION (past and present)
1. Recent Treatment History

Date	Reason	Results
Last physical check-up		
Last Doctor's visit		
Last Dental visit		

2. Review of Past/Present Conditions

Please check any of the following medical problems you have, or have had in the past:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Adrenal problems | <input type="checkbox"/> Head Injury/Loss of Consciousness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Allergies | |

If yes to any of the above, please describe and give dates: _____

3) Current Medical Symptoms/Problems:

Please check all that pertain to you now:

- | | | |
|---|---|---|
| <p><u>EYES</u></p> <p><input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Problems with vision</p> <p><u>EARS</u></p> <p><input type="checkbox"/> Hearing Aid</p> <p><input type="checkbox"/> Buzzing/Ringing in ears</p> <p><input type="checkbox"/> Infection in ears</p> <p><input checked="" type="checkbox"/> Problems with balancing</p> <p><input type="checkbox"/> Problems with hearing</p> <p><u>NOSE</u></p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Stuffy nose</p> <p><u>MOUTH</u></p> <p><input type="checkbox"/> Loss of taste</p> <p><input type="checkbox"/> Problems with teeth</p> <p><input type="checkbox"/> Dentures</p> <p>irregularities</p> <p>Menopause</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Sputum/mucus production</p> <p><input type="checkbox"/> Positive TB test</p> <p><input type="checkbox"/> Coughing up blood</p> <p><u>SKIN/JOINT/MUSCLE</u></p> <p><input type="checkbox"/> Changes in skin</p> <p><input type="checkbox"/> Changes in nails</p> <p><input type="checkbox"/> Changes in hair</p> <p><input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> Skin itchy/dry</p> | <p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Black tarry stool</p> <p><input type="checkbox"/> Abdominal pain</p> <p><u>GENITO/URINARY</u></p> <p><input type="checkbox"/> Pain/burning with urination</p> <p><input type="checkbox"/> Frequent urination at night</p> <p><input type="checkbox"/> Bloody/brown urine</p> <p><input type="checkbox"/> Difficulty starting urine flow</p> <p><input type="checkbox"/> Constant need to urinate</p> <p><u>NERVOUS SYSTEM</u></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Convulsions/seizures</p> <p><input type="checkbox"/> Memory problems</p> <p><input type="checkbox"/> Coordination problems</p> <p><input type="checkbox"/> Tremor/shakes</p> <p><input type="checkbox"/> Loss of movement</p> <p><input type="checkbox"/> Loss of sensation</p> | <p><u>GENERAL HEALTH</u></p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Underweight</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Tire easily</p> <p><input type="checkbox"/> Night/day sweats</p> <p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Heart skips a beat</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Fast heart rate</p> <p><input type="checkbox"/> Chest pains</p> <p><input type="checkbox"/> Swollen ankles</p> <p><u>FEMALES ONLY</u></p> <p><input type="checkbox"/> Menstrual irregularities</p> <p><input type="checkbox"/> Problem pregnancy</p> <p><input type="checkbox"/> Miscarriage # _____</p> <p><input type="checkbox"/> Abortion # _____</p> <p><input type="checkbox"/> Premenstrual problems</p> <p><input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Currently pregnant</p> |
|---|---|---|

- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

If you checked any of the above, please describe: _____

4) Medication and Drug Use

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose: Yes No If yes, please describe:

Any medication allergies? Yes No If yes, please describe: _____

Do you believe you would benefit from any of the following?

- Anger Management Education Series
- Substance Abuse Education Series
- Grief Group

STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 10
 yes no n/a

Referred for physical yes no

_CLINICIAN SIGNATURE/CREDENTIALS

DATE

The Center for Counseling

Your Life Is Precious.™

32743 23 Mile Road
New Baltimore, MI 48047
Phone 586.273.7095, Fax 586.273.7196

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client/Guardian

Date of birth

I hereby freely and voluntarily authorized The Center for Counseling to.....

_____ Release/disclose my protected health information to:

_____ Obtain my protected health information from:

(Individual, Facility, or Organization)

(Phone Number)

(Address)

(Fax Number)

(City, State, Zip Code)

The purpose of this disclosure is for:

_____ educational placement

_____ legal reasons

_____ Insurance/billing

_____ medical treatment

_____ discharge planning

_____ continued treatment

_____ The client

_____ progress update

_____ other _____

Information to be used or disclosed:

_____ Discharge summary

_____ psychiatric eval

_____ mental status

_____ History

_____ testing

_____ treatment plans

_____ Progress

_____ attendance

_____ prognosis

_____ Drug/alcohol history

_____ entire record

_____ other _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to The Center for Counseling, except to the extent that action has already been taken in reliance on it. This authorization will expire 90 days () following discharge, or () following signature unless another date or condition is specified. Other date or condition specified: _____

Client/Guardian

Date

Witness

Date

*Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ANGER MANAGEMENT EDUCATION

Clinician	Starting Date	Today's Date
Probation Officer Phone Fax	Case Number	Faxed Date

Name _____

Home Phone _____ Alternate Phone _____

Address _____ City _____ Zip _____

Age _____ Date of Birth _____ Sex Male Female

Social Security Number _____

Drivers License Number _____

Emergency Contact _____ Phone _____

Referred by (court number) _____

Previous therapy elsewhere? yes no Where? _____

Please have your Driver's License available for office staff to copy, your \$45 registration.

OFFICE USE ONLY

Registration faxed to court/probation officer _____ (date/initials)

No Call No Show faxed to court/probation officer _____ (date/initials)

Missed Groups 1 2 3 4 5 6

Final report faxed to court/probation officer _____ (date/initials)

Client Name: _____

Your therapist name is: _____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERGENCY: CALL 911

If you believe you are in danger or in imminent risk, suicidal or homicidal with intent: Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but proceed to the emergency room immediately.

Business Hours:

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-273.7095. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = \$45, 30-60 minutes = \$90, and after 60 minutes, the charge will be \$1.00 per additional minute. _____

Before/After Business Hours:

If an urgent matter arises which you would like to discuss with your clinician, **dial 1-586-273-7095** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100**. The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client Address _____

Client Phone _____

Client/Guardian Signature _____

Date _____

Clinician Signature/Credentials

Date

For further information about this
Privacy Notice, please contact:

The Center for Counseling
Office Manager
586.273.7095

The Center for Counseling is
accredited by the Joint Commission on
Accreditation of Healthcare
Organizations.

This notice is effective as of July 7,
2003. (This date must not be earlier
than the date on which the notice is
printed or published.)



The Center for Counseling

Your Life Is Precious.SM

**32743 23 Mile Road, Suite 130
New Baltimore, MI 48047**

www.thecenterforcounseling.net

Notice of Privacy Policies and Practices

**Our promise to you
on the privacy of
your health
information**



The Center for Counseling

Your Life Is Precious.SM

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND MADE KNOWN, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for the purpose of providing you with quality mental health and substance abuse care.
- Your private healthcare information may be released to your insurance company for the purpose of The Center for Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by the agency to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The agency is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- The agency will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the agency:

The Center for Counseling
ATTN: Office Manager
32743 23 Mile Road
New Baltimore, MI 48047

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency.

RULES & EXPECTATIONS FOR EDUCATIONAL SERIES

- A release of information must be signed so that information can be released to the court.
- Pay a registration fee, which will be used as payment for last group session. If for any reason you do not complete group this registration fee is non-refundable.
- Final reports will not be released unless all payments are made in full.
- Your group session rate will be charged if you do not give a minimum of 24 hour notice for cancellations. (Voice mail is on whenever office is closed and you can leave a message, which we can get date and time from)
- No admittance to group if you are later than 5 minutes after the group start time. You will have to make up the group session the next time around.
- Courts will be notified if you miss initial group session.
- Court will be notified if 2 group sessions are missed.
- If 2 sessions are missed you must start the series over. If you miss one session it must be made up the next series or you must start over.
- If you are under the influence of any mood altering substance you will be asked to leave group for the week. You will be allowed to return the next week and make up the group you were asked to leave.
- If you come to group twice under the influence you will be discharged from group and your probation officer will be notified.
- Participation and appropriate behavior during group is required

I have read and understand the above rules and expectations for group sessions.

Student Signature/Date

Staff Signature/Date

Z:/CENTER FOR COUNSELING/FORMS/RULES FOR GROUP