Stacy Campbell, LLC at
Nampa Valley Counseling Center

320 11th Avenue S – Suite 205 – Nampa – ID - 83651 – 208.577.1595 – 208-906-2338 (FAX)

Client Information

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date _____ Referred by_____

Name _____ □M □F Birth Date _____/____/_____

School _____ Grade_____

Parent Name _____ Parent Birthday _____/_____/_____
□ Father - □ Mother - □ Legal Guardian - □ Foster Parent - □ Other _____
Married to/In a Relationship with: _____
Occupation/Employer: _____

Address _____
Street Apt. # City Zip
Is this your child's primary residence? □ Yes □ No

Primary phone _____ Okay to leave message/text? □ Yes □ No

Work phone _____ Okay to leave message/text? □ Yes □ No

Parent Name _____ Parent Birthday _____/_____/_____
□ Father - □ Mother - □ Legal Guardian - □ Foster Parent - □ Other _____
Married to/In a Relationship with: _____
Occupation/Employer: _____

Address _____
Street Apt. # City Zip
Is this your child's primary residence? □ Yes □ No

Primary phone _____ Okay to leave message/text? □ Yes □ No

Work phone _____ Okay to leave message/text? □ Yes □ No

Emergency Contact:

Name: _____ Phone: _____

Relationship to Client: _____

Payment and Insurance Information Sheet

Client Name_____ Birth Date _____

Who is financially responsible for payment: _____
Insurance: Yes □ No □

If yes, Insurance Company: _____
Policy Number _____ Group Number _____

Deductible $_____ Amount met $_____ Copay $ _____ # of allowed visits_____

Is the client's condition related to:
Employment: □ YES / □ NO Auto Accident: □ YES / □ NO Other Accident: □ YES / □ NO

Please Print exactly as it appears on your Insurance Card
Insured's Name_____ Birth Date _____ Gender: M / F
Insured's Address:_____ Primary Phone _____
Insured's employer _____
Client's Relationship to Insured: Self □ Spouse □ Child □ Other □

Fees (if applicable), copayments, and deductible payments are due at each session.

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services through Stacy Campbell, LLC. I give consent to and acknowledge that my information may be viewed by approved billing personnel. In addition, I understand that I am responsible for payment should insurance fail or deny payment for services rendered.

_____

Client (Parent/Guardian) Signature Date

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Informed Consent and Client Rights

Welcome to Stacy Campbell, LLC at Nampa Valley Counseling Center. This document contains important information regarding my services, therapeutic approach, confidentiality, your rights, and business policies. If you have any questions, please ask for further information.

Counseling Purpose
Counseling is a professional relationship designed to empower diverse individuals, families, and groups to accomplish mental health, wellness, education, relationship, and career goals. According to the U.S. Dept. of Human Services, the primary purpose of counseling is to empower you to deal adequately with life situations, reduce stress, experience personal growth, and make well-informed rational decisions.

Training and Therapeutic Approach
I am a Licensed Clinical Professional Counselor (LCPC-5865) in the State of Idaho and a nationally recognized Registered Play Therapist (RPT-T2870). I have a Master's degree in Mental Health Counseling from Capella University and completed post-graduate play therapy courses and supervision from Northwest Nazarene University. My therapeutic framework is based on a person-centered belief system. As the counselor provides a warm, non-judgmental, and empathic environment, the client is then able to recognize their true potential and bring forth change towards self-actualization. My person-centered beliefs also translate to my work with children as I utilize a child-centered play therapy framework when working with younger clients. Just as adults move towards self-actualization, under the belief system of child-centered play therapy theory, children are continuously working towards growth and maturity. When provided with a therapeutic environment, children are able to move through challenging life circumstances and learn more appropriate ways to navigate their world. While the root of my therapeutic approach lies in the person-centered/child-centered framework, it is important to understand that, at times, it may be necessary to pull interventions from other therapeutic modalities. This most commonly includes cognitive-behavioral interventions (including cognitive-behavioral play interventions), strengths-based interventions, and family-systems therapeutic activities. It is important for you to communicate how you feel about the treatment approach as an adjustment to therapeutic approach might be necessary.

Counseling Process
The counseling process will begin with the creation of personalized therapy goals. We will work collaboratively to create goals that are attainable and help you (and/or your child/family) get where you want to be. Goals for therapy tend to center on symptom reduction, improved relationships, gained insight, and learning necessary skills to manage the challenges of life. Once therapeutic goals are created, the counseling process continues with ongoing sessions focusing on the exploration of feelings, thoughts, motivations, and relationship dynamics. As the counseling process progresses, gradual shifts in thoughts, feelings, and behaviors typically occur and often times substantial therapeutic progress is made. Complete therapeutic success largely depends on the individual. If you remain committed, open, and honest, positive outcomes are likely. While benefits of counseling are expected, specific results cannot be guaranteed. If you feel as though progress is not being made, you should discuss this with your counselor. If you continue to feel as though counseling is unsuccessful, you should request a counselor change or referral. I will always be glad to give as many referrals as needed.

Play Therapy Experience
I am a trained and credentialed play therapist. As such, I offer a unique experience to children and anyone seeking out an alternative therapy experience. In my office, a client will find toys, art supplies, and sand to support the therapeutic experience. These supplies are used by children (and adults if they so desire) to build resilience, work through past hurts, and gain skills in ways that are unique to the individual. I also have been so fortunate to have an office with a built-in tree house. I will make every effort to ensure safety with children that desire to use the tree house, however, if you feel that your child cannot be safe using this toy, then it is your responsibility to communicate that with me and I will ensure that your child does not engage with it during session.

Counseling Risks and Benefits
Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes could impact your relationships with significant others in both positive and negative ways. At times, counseling can involve remembering unpleasant events and may arouse strong emotional feelings. When working with children, behavioral challenges may increase for a short time while they are adjusting to new insight and changed parenting techniques. The benefits of counseling may include improved ability to relate with others, a clearer understanding of self, values, goals, increased academic or work productivity, and an ability to deal with everyday stress more effectively. Taking personal responsibility for working through these issues may lead to greater growth and positive outcomes.

Counseling Sessions, Cancellation Policy, and Emergency Procedures
Counseling sessions are normally 40 to 50 minutes in length. Typical office hours for scheduling regular appointments are between 9am and 6pm, Monday through Friday. Sessions are typically scheduled once a week depending on the need. The average individual will come for two to six months but the length can vary greatly. Counseling sessions may include just the individual adult or child, or be a couple, family, parent and child dyad, or a family/parent consultation session to support the individual child client. We will create a counseling schedule to support you (and your family's) specific needs. Changes to scheduled appointments, including cancellations must be done 24 hours in advance and can be done by calling 208-577-1595. Failure to give notice for two consecutive appointment cancellations (no-shows) may result in the termination of the counseling relationship. If ongoing cancellations become problematic, a discussion of the therapeutic treatment will occur and a decision will be made to support the client and counselor in the best possible way. If you are in crisis or have an emergency, you may contact your local police at 911 or go to your nearest emergency room. You may also call 208-577-1595 as this number serves as on-call for emergency and after hour needs. I will give notice of any planned time away and will create a plan with you to address your counseling needs during extended vacations or professional conferences during my absence.

Documentation
Documentation is maintained regarding the counseling services you receive. You have the right to access your counseling records with written request. There will be small fee for copying these records. If in my professional opinion, I find that releasing your counseling records may cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to you or another individual it will be strongly recommended to receive a treatment summary of these records. Given their inclusion of professional language, case notes are typically not released to anyone even when specifically requested. Records are kept for 7 years and will be destroyed after that time. Documentation that is just in written form will be stored at the office in a HIPPA compliant manner and in accordance with relevant laws and statutes. Client information is managed and stored through an EHR system that is HIPPA compliant.

Diagnosis
If a third party, such as an insurance company, is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. This will be determined during our initial evaluation and may be changed or be amended throughout the counseling process.

Professional Standards:
As a Licensed Clinical Professional Counselor, I am required by the State of Idaho to adhere to the ACA Code of Ethics. A copy of this can be provided upon request. In addition to the ACA Code of Ethics, I also adhere to the Association for Play Therapy Best Practices. This can be provided upon request.

Therapeutic Relationship
Counseling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals. At times this process may feel very intimate. Our relationship is a professional one in which I am providing clinical services for an agreed upon fee. Our contact will be limited to the agreed upon schedule, except in the case of emergency. Invitations to events, offering of gifts or interactions outside of our agreed upon treatment schedule will be talked about between you the client and myself the professional. In most cases these offers and invitations will be declined due to any possible effect it may have on my objectivity, clinical judgment and therapeutic effectiveness provided to you the client. Progression towards your goals will best be served if our sessions and communication concentrate

exclusively on your goals and clinical concerns. Sexual intimate relationships are NEVER appropriate with client or client relatives and should be reported to the Idaho Bureau of Occupational Licenses immediately.

Social Media
Counselors may maintain both a Personal and Professional presence in social media. Counselors may not and will not respond to any request and/or comment placed by individuals that may disclose confidential information. Counselors maintain appropriate boundaries with clients and clients' families in regard to social media presence and electronic presence. Counselors will not search out or initiate contact with clients through any social media or technology means without written consent from client.

Electronic Communication
At this time, I do not respond to e-mail due to the lack of confidentiality through this means of communication. If you choose or ask to send an e-mail, it is important to understand that I do not use an encryption program at this time, although I do use a secure google account. Furthermore, I cannot ensure that e-mail messages will be received if I am not available. E-mail is not the appropraite way to communicate confidential, urgent, or emergency information. Therefore, you are encouraged to contact me at 208-577-1595 if you have urgent needs. If you have simple scheduling needs/questions or would like a call back at my discretion, texting is acceptable. Detailed client/counseling questions will not be answered via text and you can expect a call at my earliest convenience.

Confidentiality
In general, the law protects the confidentiality of all communications between a client and counselor, and I can only release information to others about your counseling only with your written permission (in the form of a Release of Information).
However, there are a number of exceptions where information may be shared without your written permission. The limitations of confidentiality are as follows:

- Client reports a serious and foreseeable danger to self / others
- Client reports a contagious, life threating disease
- Child or Elder being abused / neglected
- Individual unable to care for themselves is being abused / neglected
- Client is below 18 years of age, parents have rights to therapeutic information
- Client requests release of information
- Court orders
- Subordinates who process client information and papers
- Clinical supervision/consultation
- Legal and clinical consultation situations
- Third Party Payers requests relevant clinical information.

When a family or couple comes in for counseling, I will uphold their right to confidentiality. Within the family unit, I will encourage any "secret" relevant to counseling to be disclosed by the member holding it. When meeting with couples or families, in order to provide the safest therapeutic environment possible, it is my policy not to release information requested in the future without written approval by all parties. When working with minor children, it is important to respect their confidentiality as well. When working with children and parents, I will encourage the child to speak with parents openly. If any type of imminent danger is disclosed to the counselor, this will be immediately disclosed to the parent. To maintain the safety of the therapeutic process for the child, their therapy will be reviewed through their relevant play themes and parenting support will be provided.

In order to give you the highest quality service possible, I consult regularly with other counseling professionals about my work with clients. I do not refer to any clients by name. I am happy to disclose to you the names of professionals I may consult with regarding your situation.

I use an EHR (electronic health records) online software program, an electronic faxing system which is shared with counselors providing services at Nampa Valley Counseling Center, as well as Square, Inc for payments. I have a Business Associate Agreement with all programs which guarantees that they also maintain your information under HIPPA compliance.

Court Disclosure
It is my policy NOT to provide clinical evaluations or assessments to fulfill court requirements or for other legal purposes including child custody. I will not be involved in court-oriented activities, including testifying in custody matters. It is my intent to support you (or your child) therapeutically and not to enter into legal proceedings. I will not give legal opinions or recommendations regarding custody or custodial issues. In the unlikely event that I am subpoenaed as a witness by a judge, fees for the requesting party are billed at $300 per hour with a minimum four-hour charge. All time will be billed including preparation time, drive time, time spent waiting to testify, and actual time spent on testimony. Such fees are not billable to insurance and are due a minimum of one week before the scheduled court appearance. Fees are not refundable, despite any cancellation made within 24 hours.

Grievance/Complaints
All complaints should be addressed directly with your counselor. You have the right to make complaints regarding ethical concerns to the Bureau of Occupational Licenses. If a client files a complaint or lawsuit, the counselor may disclose relevant information regarding the client in order to defend itself.

The Idaho Bureau of Occupational Licenses
700 West State Street, Boise, ID 83702
(208) 334-3233
http://ibol.idaho.gov/IBOL

Fees:
This information is provided to prevent any misunderstandings so that your time in counseling can be focused on your emotional needs and not financial issues. As a courtesy, I will bill your primary insurance company or provide receipts for your own billing. Please be aware that in order to accomplish this we will be supplying your insurance provider(s) with information necessary to complete the billing process. I ask that you pay your co-pay at each session or the entire fee until insurance coverage has been established. In the event you have not met your deductible for the year, the full fee is due at each session until the deductible is satisfied.
If insurance is not being billed, fees will be due at each session.

Services Billable to Insurance – Client May be Responsible for full fee

Initial Diagnostic Interviews	60-90 minutes	$140
Individual/Family/Couples	30-52 minutes	$95 - $100
Individual Extended Session	52-90 minutes	$115
Play Therapy Addition	30–52 minutes	$13

Fees & Services Not Billable to Insurance – Client Responsible

Consultations/School Meeting	30-60 minutes	$60.00-100.00
Professional Service Fees*	30 minutes	$40.00
Legal Proceedings (Including wait & travel time)	60 minutes	$300.00
Record Copying Fee		$.30 per page

*Professional services fees may include, but not limited to, report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Travel and waiting time will also be incurred.

Client Rights and Responsibilities

Client Rights:

- You have the right to privacy and confidentiality.
- You have the right to not be discriminated against or treated unfairly due to race, ethnicity, nationality, gender, sexual orientation, or religion, age, mental of physical disability, medical condition, medical history, claims experience, evidence of insurability, or source of payment.
- You have the right to be a participant in treatment decisions.
- You have the right to seek a second opinion.
- You have the right to file a complaint without retaliation.

- You have the right to refuse treatment and/or any services or treatment modalities and be advised of the consequences of refusal.
- You have the right to obtain clear information about your records.
- You have a right to participate in the ongoing counseling plans.

Client Responsibilities:

- You are responsible for attending appointments as scheduled or giving 24 hour notice if you cannot attend.
- You are responsible for participating in treatment and following through with homework or other tasks assigned by your counselor
- You are responsible for expressing concerns or complaints that you have to your counselor.
- You are responsible for maintaining personal boundaries and respecting boundaries that may be set by your counselor.

Clients have rights protected by State and/or Federal law, and Professional ethical standards. For information contact: Idaho Bureau of Occupational Licenses Physical Address: 700 West State Street, Boise, ID 83702. Mailing Address: PO Box 83720, Boise, Idaho 83720-0063

Please sign this sheet to indicate that you have read the informed consent information and understand your rights as a client. Also by signing this you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive counseling services through Stacy Campbell, LCPC, RPT.

_____

Client Name (Printed)

_____ _____

Client/Parent/Legal Guardian Signature Date Counselor Signature Date

BIOPSYCHOSOCIAL HISTORY

Name: _____ Date: _____

Date of Birth: _____

REASONS YOU ARE HERE TODAY?

1. _____
2. _____
3. _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

	Never	Sometimes	Frequently		Never	Sometimes	Frequently		Never	Sometimes	Frequently
feeling low/down/sad	[ ]	[ ]	[ ]	bingeing/purging	[ ]	[ ]	[ ]	nervousness	[ ]	[ ]	[ ]
diminished pleasure/joy	[ ]	[ ]	[ ]	drug/alcohol use	[ ]	[ ]	[ ]	nightmares	[ ]	[ ]	[ ]
eating too little/too much	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	increased sexual behaviors	[ ]	[ ]	[ ]
weight loss	[ ]	[ ]	[ ]	overly suspicious	[ ]	[ ]	[ ]	chronic illness	[ ]	[ ]	[ ]
insomnia/hypersomnia	[ ]	[ ]	[ ]	dwelling/fixation	[ ]	[ ]	[ ]	pains/aches	[ ]	[ ]	[ ]
restlessness	[ ]	[ ]	[ ]	elimination problems	[ ]	[ ]	[ ]	cutting/burning self	[ ]	[ ]	[ ]
fatigue/loss of energy	[ ]	[ ]	[ ]	easily distracted	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]
worthlessness	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	problems with intimacy	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	arguments/fighting	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	impulsivity	[ ]	[ ]	[ ]	temper-tantrums	[ ]	[ ]	[ ]
property destruction	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	physical harm to others	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	over-sexualized behaviors	[ ]	[ ]	[ ]
worry/fears	[ ]	[ ]	[ ]	grief/loss	[ ]	[ ]	[ ]	thoughts of ending your life	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	thoughts of harming others	[ ]	[ ]	[ ]
overreactions	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	history of self-harm	[ ]	[ ]	[ ]
guilt	[ ]	[ ]	[ ]	anger problems	[ ]	[ ]	[ ]				

TRAUMA, ABUSE, OR LOSS HISTORY

[ ] [ ] Have you (or your child) experienced any significant trauma, abuse (including being a perpetrator of abuse) or loss?

No Yes If yes, please briefly describe

_____

_____

TREATMENT HISTORY

[ ] [ ] Additional or Past <u>out</u>patient counseling/therapy (includes Counseling, OT, Speech, Feeding, Physical, Equine etc)?

No Yes If yes, who have you seen?

Prior provider name Dates Seen? Beneficial?

_____

_____

[ ] [ ] Has any family member had outpatient counseling/therapy? If yes, who/why (list all):_____

No Yes _____

[ ] [ ] Prior <u>Psychiatric Hospitalization(s)</u>

No Yes If yes, what was the name of the facility

Psychiatric Hospital Name Month/Year Attended

_____

_____

[ ] [ ] Has any family member been in a psychiatric hospital? If yes,

No Yes who/why (list all):_____

[ ] [ ] Current mental health medications? If yes:

No Yes Medication Dosage Frequency Physician Side effects

_____

_____

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FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

_____

Parents' current marital status:

[ ] married to each other
[ ] separated for ___ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___
[ ] Parents Cohabitating

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ____ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction: [ ] N/A

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Frequency of visitation of above: _____

MEDICAL HISTORY (check all that apply for client)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

_____

List name of primary care physician: [ ] None
Name _____ Phone _____
Date of last physical: _____
List name of psychiatrist: (if any): [ ] None
Name_____ Phone_____
List Current and Past Physical Illnesses: _____
_____
List current non-mental health medications (give dosage & reason):

_____

List any known allergies: [ ] NKA [ ] Peanut Allergy_____
_____

Is there a history of any of the following in the family:

[ ] tuberculosis [ ] heart disease
[ ] birth defects [ ] high blood pressure
[ ] emotional problems [ ] alcoholism

[ ] behavior problems [ ] drug abuse
[ ] thyroid problems [ ] diabetes
[ ] cancer [ ] Alzheimer's disease/dementia
[ ] mental retardation [ ] stroke
[ ] other chronic or serious health problems _____

_____

Describe any serious hospitalization or accidents:

Date _____ Age ____ Reason _____
Date _____ Age ____ Reason _____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Employment:

Current Occupation:
_____

[ ] employed and satisfied
[ ]employed but dissatisfied
[ ] unemployed
[ ] student
[ ] co-worker conflicts
[ ] unstable work history
[ ] disabled: _____

Living Situation:

[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] living companions dysfunctional

Legal history:

[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s)
[ ] court ordered to treatment
[ ] jail/prison _____ time(s)
[ ] custody case in progress

Cultural/spiritual/recreational history:

cultural identity (ethnicity, race, religion):
_____

describe any cultural issues that contribute to current problem:

_____

hobbies/community/recreational activities: _____

_____

currently engaged in said activities? Yes [ ] No [ ]
currently engaged in spiritual activities? Yes [ ] No [ ]
if "yes", please describe _____
_____
_____

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Financial situation:

[ ] no current financial problems
[ ] relationship conflicts over finances
[ ] impulsive spending
[ ] cannot pay bills
[ ] finances are tight

Education: Highest Level of Education: [ ] Graduate School [ ] College [ ] High School [ ] GED

Current School: _____ Grade: _____

Grades: [ ] Above Average [ ] Average [ ] Below Average [ ] Failing One or More Classes

Friends: [ ] Many Friends [ ] Some Friends [ ] Few Friends [ ] No Friends [ ] Gets in Fights

DEVELOPMENTAL HISTORY (check all that apply for a **child/adolescent clients**)

Problems during/after mother's pregnancy:

[ ] none
[ ] Depression/anxiety
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:

[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight ____lbs ___oz.

Infancy:

[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:

[ ] chickenpox (age _____)
[ ] German measles (age _____)
[ ] red measles (age _____)
[ ] rheumatic fever (age _____)
[ ] whooping cough (age _____)
[ ] scarlet fever (age _____)
[ ] autism
[ ] ear infections
[ ] allergies to _____
[ ] significant injuries _____
[ ] chronic, serious health problems _____
_____
[ ] lead poising (age _____)
[ ] mumps (age _____)
[ ] diphtheria (age _____)
[ ] poliomyelitis (age _____)
[ ] pneumonia (age _____)
[ ] tuberculosis (age _____)
[ ] mental retardation
[ ] asthma

Delayed developmental milestones (check only those milestones that did not occur at expected age):

[ ] met milestones on time
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] sitting
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively

Behavior problems (check all that apply):

[ ] breaks things
[ ] easily distracted
[ ] lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] distrustful
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] frequently daydreams
[ ] indecisive
[ ] immature
[ ] meltdowns
[ ] self-injurious acts
[ ] sexual behavior: If checked, please indicate if there is risk such as unprotected sex or multiple partners _____
_____

Social interaction (check all that apply):

[ ] normal social interaction
[ ] keeps to self
[ ] very shy
[ ] pushes others away
[ ] inappropriate sex play
[ ] bossy to others
[ ] associates with negative friends
[ ] other:_____

Intellectual functioning (check all that apply):

[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation

SUBSTANCE USE HISTORY (check all that apply for **clients 10 yrs. and older**)

Family alcohol/drug abuse history:

[ ] father
[ ] mother
[ ] grandparent(s)
[ ] sibling(s)
[ ] other _____
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] spouse/significant other
[ ] children

Substances client has used: [ ] None

(complete all that apply)	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] Alcohol					
[ ] Marijuana					
[ ] Cigarettes					
[ ] Caffeine					
[ ] Prescriptions					
[ ] Hard drugs (Cocaine, crack, LSD, PCP, Meth)					
[ ] inhalants (e.g., glue, gas)					

Substance Abuse Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)
[ ] stopped on own (age[s]_____)
[ ] other (age[s]_____)
describe:_____

Consequences of substance abuse (check all that apply):

[ ] hangovers
[ ] seizures
[ ] blackouts
[ ] overdose
[ ] withdrawal symptoms
[ ] medical conditions
[ ] tolerance changes
[ ] relationship conflicts
[ ] sleep disturbance
[ ] assaults
[ ] suicidal impulse
[ ] loss of control over amount used
[ ] binges
[ ] job loss
[ ] arrests

Clinician Reviewed: _____ Date:_____

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320 11th Avenue S – Suite 205 – Nampa – ID - 83651 - 208-577-1595

HIPAA Consent Form
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Please sign below to indicate that you have reviewed the HIPAA Notice of Privacy Practices and understand that you may request a copy of the HIPAA Notice of Privacy Practices at any time.

_____

Printed Name

_____

Client (Parent/Guardian) signature

_____

Date