Teen Client Information

Client's Name (First MI Last):

Preferred Name or Nickname:

Date of Birth: Age: Gender:

Parent/Caregiver 1	Parent/Caregiver 2
Name:	Name:
☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:	☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:
Mailing Address:	Mailing Address:
Physical Address:	Physical Address:

Please DO NOT list any numbers where you would prefer not to receive calls or messages.

Home:	Home:
Cell:	Cell:
Work:	Work:
Email:	Email:
Check this box to receive email communication from Counseling Associates ☐	*Check this box to receive email communication from Counseling Associates* ☐

As a courtesy, we offer the option of appointment reminders by email, text, or landline phone message.
These messages are delivered 48-hours in advance. These serve as reminders only and should not be relied upon exclusively.
Please also be sure to note your appointment in your own personal calendar.

Would you like to receive optional courtesy reminders? ☐ Yes ☐ No

Requested Method: ☐ Email ☐ Text ☐ Landline Phone Message *(select one only)*

Insurance Information

Primary Insurance Company:	Secondary Insurance Company:
ID#:	ID#:
Group #:	Group #:

Please provide your insurance card(s) for copying at the time of appointment or upload a photo of the front and back of your card(s) via our secure portal on ca-mh.com.

Payment Authorization

Type of Credit Card: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX

Name on Card: eSignature:

Card Number:

Expiration Date: Security Code (CVV):

Street or P.O. Box **Number**: Zip Code:

Options: *Check all that apply*

- ☐ Use for my co-payment for each session
- ☐ Use only when I call to give authorization
- ☐ Use for any balance for which I am responsible
- ☐ Use for balances on late cancellations or missed sessions

Special Instructions:

Financial Agreement

I understand that I am financially responsible for any and all costs associated with services which are considered part of my deductible, co-payment, and/or co-insurance stated by my insurance, and services my behavioral health insurance does not cover. Counseling Associates of New London, PLLC (including Counseling Associates of Newport, Counseling Associates of Claremont, and Counseling Associates of the Upper Valley), requires payment at the time of service.

I understand that I am responsible for notifying Counseling Associates of any insurance changes. If I do not contact Counseling Associates of New London, PLLC (including Counseling Associates of Newport, Counseling Associates of Claremont, and Counseling Associates of the Upper Valley), with insurance changes before my next appointment, I will be responsible for paying in full any charges incurred for services provided that are not covered by my new insurance.

I authorize the release of information necessary to file a claim with my insurance company, including electronically, for insurance payment to be made to Counseling Associates of New London, PLLC. A copy of this signature is as valid as the original.

Appointment Cancellation Policy: We have a standard 24-hour cancellation policy and $60.00 missed session fee. Please notify your therapist of cancellation at least 24 hours prior to your appointment to avoid the $60.00 fee. Missed sessions cannot be charged to insurance.

Signature _____ Date _____

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your child's primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your child's PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

- ☐ I authorize coordination of care between my child's PCP and Counseling Associates. ***Please sign release on following page.***
- ☐ I decline coordination of care at this time. ***Do not complete release on following page.***
- ☐ I have questions about coordination of care and would like to wait and speak with my child's therapist.
- ☐ My child has other providers or individuals for whom I would like to authorize communlcations. ***Please sign release on following page***

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- Notification of Privacy Policies Regarding Protected Health Information (PHI)
- Telebehavorial Health Informed Consent
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering for my child. I have had all of my questions answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my child's treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my child's therapist's control. (e.g. if my child's treatment has been court-ordered. I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering for my child, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, and the Upper Valley. I consent for my child to receive services from Counseling Associates and I agree to take an active role in my child's treatment.

Signature of Parent/Guardian _____ Date _____

Printed name _____ Relationship to client _____

Signature of Provider _____ Date _____

Please Tell Us

In a sentence or two, please describe the reason for the appointment:

What do you hope to gain from therapy?

What strengths do you have that you will bring to this work?

Have you seen a therapist before? ☐ Yes ☐ No
If Yes, please note the name of the therapist(s) and approximate date(s):

Health Information

Primary Care Provider:	Date of Last Physical:
Other Providers:	
Current Health: ☐ Good ☐ Fair ☐ Poor	Are you concerned about your health? ☐ Yes ☐ No
Allergies:	☐ No Known Drug Allergies

Current Medications

Medication	Dosage	Medication	Dosage

Please attach additional sheet(s) as needed for additional medication information.

Authorization to Disclose Health Information

_____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, Newport, Claremont, & Upper Valley** to

☐ Release ☐ Receive ☐ Exchange

Protected Health Information (PHI) about the above referenced individual to:

Name:	Phone:
Address:	

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ Mental Health (MH) ☐ Substance Use Disorder (SUD) ☐ Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check ☐ **Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to: assessment, treatment plans, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.*

Check ☐ **No** if you wish to specify which of the items below to disclose:

☐ Yes	☐ No	Attendance
☐ Yes	☐ No	Assessments/Evaluations including diagnosis, treatment recommendations
☐ Yes	☐ No	Treatment Plan/Individual Plan of Care
☐ Yes	☐ No	Progress Notes
☐ Yes	☐ No	Medications Prescribed
☐ Yes	☐ No	Agency Discharge Summary/Plan
☐ Yes	☐ No	Behavioral Support Plans
☐ Yes	☐ No	Test Results (includes lab results and urine toxicology reports)
☐ Yes	☐ No	HIV/AIDS
☐ Yes	☐ No	Other (must specify):

Date range of information to be disclosed:

The purpose of the disclosure:

Date or event upon which this authorization will expire:

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

- I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be discloed without my written consent, unless otherwise allowed by the regulations or required by law.
- I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.
- For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.
- I understand that confidentiality of such records is also protected by State law.
- I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.
- I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.
- I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.
- I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print) _____ Date _____

Signature of Parent/Guardian _____ Date _____

Substance Use (To be completed by Client)

How often do you have drinks containing alcohol?

☐ 4+x/week ☐ 2-3x/week ☐ 2-4x/month ☐ monthly or less ☐ never

How many drinks containing alcohol do you have in a typical day?

Do you use tobacco? How much?

Other substances used: Frequency:

Are you concerned about your ☐ alcohol, ☐ tobacco, or ☐ other substance use?

Physical Health Issues:

Mental Health or Substance Use Treatment History, including hospitalizations:

History of self-harm? ☐ Yes or ☐ No

History of trauma, abuse, or violence? ☐ Yes or ☐ No

Substance Use, *Continued* (To be completed by Client)

Directions: *The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you.*

During the last 6 months...	Yes	No
Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, marijauna, cocaine, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)	☐	☐
Have you felt that you use too much alcohol or other drugs?	☐	☐
Have you tried to cut down or quit drinking or using alcohol or other drugs?	☐	☐
Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, counselors, or a treatment program)	☐	☐
Have you had any health problems? *For example, have you:* ☐ Had blackouts or other periods of memory loss ☐ Injured your head after drinking or using drugs ☐ Had convulsions, delirium tremens ("DTs")? ☐ Had hepatitis or other liver problems? ☐ Felt sick, shaky, or depressed when you stopped? ☐ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs? ☐ Been injured after drinking or using? ☐ Use needles to shoot drugs?	☐	☐
Has drinking or other drug use caused problems between you and your family or friends?	☐	☐
Has your drinking or other drug use caused problems at school or at work?	☐	☐
Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	☐	☐
Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	☐	☐
Are you needing to drink or use drugs more and more to get the effect you want?	☐	☐
Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	☐	☐
When drinking or using drugs, are you more likely to do something you wouldn't normally do? (Such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone)	☐	☐
Do you feel bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drinking or other drug problem?	☐	☐
The next questions are about your lifetime experiences:	Yes	No
Have any of your family members ever had a drinking or drug problem?	☐	☐
Do you feel that you have a drinking or drug problem now?	☐	☐

Comprehensive Core Standardized Assessment (Child/Minor)

Name: DOB:

PCP: PCP Phone:

Office Location: ☐ New London ☐ Upper Valley ☐ Newport ☐ Claremont

1. Do you ever need help reading or understanding your child's health information? ☐ Yes ☐ No

2. Does your child currently use tobacco products? ☐ Yes ☐ No

3. Do you or your family currently have any legal issues that interfere with your child's healthcare? ☐ Yes ☐ No

4. What is your family's housing situation today?

- ☐ We don't have housing (couch surfing, motel, on the street, vehicle, abondoned building or a homeless shelter)
- ☐ We have housing today, but I'm worried we might lose it in the next 90 days
- ☐ We have housing that is safe and adequate

5. In your child's housing situation, do you have issues with any of the following?

☐ Lead paint or pipes ☐ Bug infestation ☐ Mold

☐ Oven or stove does not work ☐ No smoke detector/detectors do not work

☐ Other: _____ ☐ None

6. How hard is it for you to pay for your family's basic needs of food, housing, heat, or medical care?

☐ Not hard at all ☐ Somewhat hard ☐ Very hard

If **Somewhat hard** or **Very hard**, what do you have trouble paying for? *(Check all that apply)*

☐ Food ☐ Health Needs ☐ Utility bills (electric, oil, propane, etc.)

☐ Housing ☐ Childcare ☐ Debts ☐ Other:_____

7. Does your child need assistance with any of the following tasks?

☐ Bathing ☐ Getting in or out of chairs ☐ Grooming ☐ Dressing

☐ Walking ☐ Eating ☐ Using the toilet ☐ No, I do not have difficulty with these activities

8. Does your child have someone they could call for help or a favor? ☐ Yes ☐ No

9. In the last 12 months, has your child or anyone in your household been threatened or abused physically, emotionally, or sexually by a partner, spouse, or family member? ☐ Yes ☐ No

10. Do you have any concerns related to your child's health? ☐ Yes ☐ No

Patient Health Questionnaire (To be completed by Client)

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Column Totals: 0 + 0 + 0 + 0

Total Score: 0

General Anxiety Disorder Screening (To be completed by Client)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid, as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3

Column Totals: 0 + 0 + 0 + 0

Total Score: 0

SUBMIT