LIFEHOUSE

PO Box 3141
Carlsbad, NM 88221
575-725-5552
www.carlsbadlifehouse.com

ADULT ASSESSMENT FORM

Name_____Date_____

Mailing Address _____May we contact you here (HIPPA) Yes____ No___

Phone (home)_____(cell)_____May we call you here (HIPPA) Yes____ No____

DOB _____ SS#_____ Marital Status_____ Gender_____

Employer_____Phone_____

Emergency contact _____Phone _____

Why are you seeking counseling services? _____

Are you <u>currently</u> experiencing any suicidal or homicidal thoughts? Please give a brief explanation.

_____

_____

Are you <u>currently</u> experiencing any safety issues/concerns (sexual abuse, domestic violence, etc.)?

Please give a brief explanation. _____

_____

Are <u>currently</u> having any hallucinations/delusions? Please give a brief explanation.

_____

_____

Are you currently having problems with substance use (alcohol, illegal, prescribed)? Please give a brief explanation. _____

_____

What program were you referred to? _____

How were you referred to Carlsbad Life House? _____

_____

EMERGENCY CONTACT (Please check YES or NO for HIPPA if we may contact this person in an Emergency)

No Personal Clinical Information will be shared at all.

1.) Name _____Relationship_____ Phone _____

Address_____ (May we call this person? HIPPA) Yes____ No_____

2.) No Personal Clinical Information will be shared at all.

2.) Name _____Relationship_____ Phone _____

Address_____ (May we call this person? HIPPA) Yes____ No_____

INSURANCE INFORMATION (If no insurance then write SELF PAY)

Primary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber DOB_____

Subscriber SS# _____

Client's Relationship to Subscriber (circle)

Self spouse child other

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber DOB_____

Subscriber SS# _____

Client's Relationship to Subscriber (circle)

Self spouse child other

Person Responsible for Payment/Subscriber _____Phone_____

Address_____City_____State_____Zip_____

SS#_____ DOB _____

Physician _____Phone _____

Psychiatrist_____Phone_____

Court Recommended: ____Yes or No____ Type of Court: _____

Judge: _____Program:_____

Are you currently on Probation? Yes_____ No_____ Which Agency _____

Probation/Parole Officer:_____ Phone Number:_____

Client Name_____

PERMISSION FOR TREATMENT

I,_____, grant permission for the staff of Carlsbad Life House to take whatever measures are clinically necessary for the assessment, evaluation, and treatment of me as a client.

I understand that signing this form does not in any way obligate me to participate in treatment for a specific length of time, nor does it obligate me to take medication nor does it in any manner affect my right as a citizen.

If any referrals or consultations are needed from other agencies or professionals, this will be discussed with me and I will be asked to sign a "Release of Information" form.

If the client needing services at Carlsbad Life House is a minor child, I, as the responsible adult (parent or guardian), grant permission for the assessment, evaluation, and treatment of the child.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Witness Signature (staff) Date

Client Name_____

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize Carlsbad Life House Inc. to disclose my individually identifiable mental health information as described below.

I, _____

Client Name Social Security Number Date of Birth

authorize Carlsbad Life House Inc. to send and receive information to and from:

Name, address & phone number of Organization:

Organization: _____ Organization: _____

Address: _____ Address: _____

Phone/Fax: _____ Phone/Fax: _____

The information/documentation to be released is at the discretion of Carlsbad Life House Inc., including but not limited to verbal communication, attendance records, and/or treatment plans.

Purpose for which records will be used are planning, appropriate Treatment/Programs, continuing Appropriate Treatment/Programs, Case Review, Updating Files, and Continuity of Care.

Legal Authority for Request (please initial)

___I am the client noted above.

___I am the client's legal guardian, and I have on file or attached to this authorization a valid appointment of guardianship from a probate court.

Understandings and Agreements of Requestor:

This authorization is voluntary and I understand that Carlsbad Life House Inc. cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatments, or (b) solely for the purpose of creating health information for the use or disclosure to a third party. I understand that I may revoke this authorization at any time by notifying Carlsbad Life House Inc in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against Carlsbad Lifehouse for the release of the requested Information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Carlsbad Life House Inc if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business that has a contract with Carlsbad Life House Inc . I understand that I must provide Carlsbad Life House Inc with a least twenty-four (24) hours' notice before coming in to review records. I understand that after I have reviewed the records, I must provide Carlsbad Life House Inc with at least two (2) working days advance notice of any copies of the records that I would like to pick up at Carlsbad Life House Inc. I understand that if I request that records be copied and sent to me that Carlsbad Life House Inc will take a good faith effort to send those records to me in a reasonable amount of time. .I understand that if I wish to have copies made, then Carlsbad Life House Inc will assess a fee for coping the records. Carlsbad Life House Inc will notify me of the total amount due for coping (and shipping if necessary) the requested records; I agree that the requested information will only be sent once payment in full for those costs has been received by Carlsbad Life House Inc.

Client/Guardian Signature:_____Date:_____

Witness Signature: _____ Date:_____

Client Name_____

CLIENT'S RIGHTS

1.) The client has the right to be treated with dignity and respect.

2.) The client has the right to refuse services.

3.) The client has the right to privacy.

4.) The client has the right that all information be treated as confidential.

There are three (3) limits to confidentiality:

a.) danger to self

b.) danger to others

c.) any suspicion of child abuse or neglect (By law, any suspicion of child abuse or neglect must be reported to Child Protective Services.)

5.) The client has the right to receive adequate and appropriate mental health services.

6.) The client has the right to have an explanation of the program in which they are being enrolled. This includes an orientation to Carlsbad Life House basic expectations, hours when services are available, cost for services, and terms of discontinuation of services.

7.) The client has the right to receive appropriate adult guidance and supervision.

8.) The client has the right to request a copy of any and all signature pages.

I have read and understand my rights.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

Client Name_____

FINANCIAL POLICY

The staff at Carlsbad Life House Inc. (hereafter referred to as this clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy which provides payment policies and options to all consumers. The financial policy of this clinic is designed to clarify the payment policies as determined by the management of this clinic.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance policy.

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the person responsible for payment of account is responsible for payment of these services. We charge our clients the usual and customary rates of the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary.

The person responsible for payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The person responsible for payment of account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health cover deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first sessions at this clinic), this amount will be collected by this clinic until the deductible payment is verified to this clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the person responsible for payment of account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor is responsible for payments for the child at the time of service. Unaccompanied minor will be denied non-emergency services unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Payment methods include cash, check, and credit card (Visa & Mastercard).

Client Name_____

NOTICE TO SELF PAY AND EDUCATIONAL GROUPS

Please be aware if the client does not have active Medicaid, Private Insurance and/or another payor source for services provided by Carlsbad Life House Inc., the client or parent/guardian will be responsible for the **full payment prior to services rendered**.

Our agency provides educational service groups to the community that could be facilitated by a provider who does not accept clients whose medical services are paid for by Medicaid and/or private insurances. These services are based on a self-pay/private payment rate established by the agency. These educational service groups are **NOT** covered by Medicaid and/or private insurances therefore these educational service groups are at clients will and client is responsible for payment prior to services rendered.

Self-Pay/Private Rate:

Initial Intake Assessment for Clinical Services:	$75.00 per service
Individual Therapy after Intake:	$60.00 per service
Marriage/Couples Counseling	
(Both Present)	$100.00 per session
(Only [1] one person present)	$75.00 per session
Adult Substance Abuse:	$20.00 per group
Adult Anger Management Group (Educational):	$20.00 per group
Parenting Group (Educational) Books are Extra:	$20.00/ per group hour
BIP (Batterers Intervention Program)	$20.00 per session A or B
Intensive Outpatient Services:	$50.00 per day
	$150.00 for three days
Adolescent Substance Abuse Group:	$12.00 per group
Adolescent Anger Management Group (Educational):	$10.00 per group
Adolescent First Offender's Program (Educational):	$60 per unit
NO Show or Late Cancellation Fee	$50 per session

Questions regarding the financial policies can be answered by the Office Manager and/or Billing Supervisor.

By signing below, I, the client, indicate that I have received a copy of this notice.

I (we) have read, understand, and agree with the provisions of the financial policy.

Person responsible for account: _____Date_____

Co-responsible party_____Date_____

Client Name_____

PRIVACY OF INFORMATION POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 4/14/03

Our Legal Duties
State and federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medicals records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.
The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggest that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Client Name_____

Professional Misconduct
Professional Misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians or non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services is the responsibility of the client, or a person who has agreed to provide payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection sources.
Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment progress of therapy, and summaries.
Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.
In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request when we phone you at home or work, to not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will stay that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voicemail, we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied you will receive a written explanation of denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $__0.25__ per page, plus postage.

Client Name_____

You have the right to cancel a release of information by providing us with written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with restriction, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints
If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the US Dept. of Health and Human Services and/or the therapist's state licensing agency. If you file a complaint we will not retaliate in any way.

_____

Direct all correspondence to: _____

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature _____Date: _____

Signed by (circle): client guardian personal representative

RECIPIENT'S RIGHTS NOTIFICATION

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a patient

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil Rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender Issues. You may request services from someone with training or experience from a specific cultural, spiritual or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences. Record restriction. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
7. Availability of records. You have the right to obtain a copy and/or inspect your protected health information. However, we may deny access to certain records in which we will discuss this decision with you.
8. Amendment of records. You have the right to request an amendment in your records. However, this request could be denied. If denied, your request will be kept in the records.
9. Medical/legal Advice. You may discuss your treatment with your doctor or attorney.
10. Disclosures. You have the right to receive an accounting of disclosures of you protected health information that you have not authorized.

Your rights to receive information

1. Medications used in you treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violation could lead to termination of services at our clinic.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
5. Policy changes.

Client Name_____

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Patient's responsibilities

1. You are responsible for following the policies of the clinic.
2. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
3. You are responsible to prove accurate information about yourself.

Risk of Non-Compliance with Treatment

1. Continued or increased symptoms of mental health and/or substance abuse
2. Continued involvement in criminal justice system, including sanctions, incarceration, probation/parole violations, new charges, etc, if applicable
3. Continued Children Youth and Family Department (CYFD), if applicable.
4. Refusal by Golden Services to provide services in the future.
5. Risky behavior associated with substance abuse and mental health symptoms.

What to do if you believe your rights have been violated

If you believe that your patient rights have been violated, contact our Recipient's Rights Advisor or Clinical Director.

Please sign below to indicate that you have received the Appeals/Grievance Process handout for your Centennial Managed Care Organization (including but not limited to BCBS, Molina, United Healthcare, Presbyterian). This should include contact information for any Human Services Division Administrative (Fair) Hearing.

_____ _____

Client/Guardian Signature Date

Waitlist for Outpatient Service
Carlsbad Life House Inc.

There is currently a waitlist greater than 14 business days at our agency. Every client is provided services upon their individual need [this could be, but is not limited to a crisis or critical incident]. Please communicate with the office if you require services within the 14 business days. This could possibly mean Carlsbad Life House Inc. refers clients to the Core Service Agency, Presbyterian Behavioral Health Services located at 913 N. Canal, Carlsbad NM.

We appreciate your patience at this time. Carlsbad Life House Inc. is working hard to continue serving the community effectively and efficiently.

By signing directly below, you indicate that the waitlist at Carlsbad Life House Inc. is understood, therefore waiving your right to be scheduled within fourteen (14) business days.

_____ _____

Client Signature Date

_____ _____

Carlsbad Life House Inc. Staff Member Date

No Show Policy

Carlsbad Life House Inc. will be expecting a courtesy call at least 24 hours ahead of your scheduled appointment if you are unable to attend. Without proper notification, there will be a charge of $75.
If you have canceled three appointments in a row or have failed to attend or cancel two appointments in a row, you will be placed on the waiting list for future services. Thank you for your cooperation in this matter.

I have read this statement and understand the terms.

_____ _____

Client Signature Date

_____

Parent/Guardian Signature

Client Name_____