ADULT INFORMATION FORM

Client's Full Name ______________________________ Age: ________ Gender: M / F

Home Address: ____

City, State, Zip: ____________________ County: ____________________

Phone numbers: Home ______________ Work ______________ Other__________

Date of Birth ___/___/___ S.S.# _____-____-_____

Home Number ( ) -	May we leave a message at this number?	YES/NO
Cell Number ( ) -	May we leave a message at this number?	YES/NO
Work Number ( ) -	May we leave a message at this number?	YES/NO

Cultural Orientation/Ethnicitiy:____________________________________

Spiritual Orientation:____________________________________

Sexual Orientation:____________________________________

Employer: ____________________________________

Name of Insurance: ____________________________________
If the insurance is not through your employer or Medicaid, who is the primary insured.

______________________ His/her date of birth: __________ S.S. #: _____-____-_____

Address: ____________________________________

Marital status of insured: Married Single Divorced Separated Widowed

Name of person responsible for any deductible, co-pay, or fees: ____________________

Address: ____________________________________

Who referred you to our office?	
Whom might we need to have a confidentiality release form signed for regarding your care?	1.____________ 2.____________ 3.____________

Physician: ______________________ Phone Number: ______________
Preferred Hospital: ____________________________________
Emergency Contact: Name/Relationship:______________________Number:__________

Completed by: ______________________________Date: __________

Revised 2020 Client ID#:______________

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

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

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

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

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

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

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

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

Now add up your "Yes" answers: ________ This is your ACE Score

Information for New Clients

The mission of Alpha Assessment & Counseling, LLC. is to provide professional counseling services to clients and their families that will enable them to make positive changes in their perceptions, emotions, and behaviors. These changes may be in one's personal life, family life, or professional life. Alpha Assessment & Counseling, LLC. provides quality and successful outcomes in behavioral healthcare which are achieved by providing access to the most appropriate care, at the right time and in the least restrictive environment. In order to accomplish this goal, Alpha Assessment & Counseling, LLC. maintains an experienced staff of clinicians on-site Monday –Friday from 9:00 a.m. until 5:30p.m. with availability 24 hours a day, seven day a week for urgent or emergency situations.

NOTICE OF PRIVACY PRACTICES

(HIPAA) – Health Portability & Accountability Act

This document contains important information about our professional services and business policies. It also contains summary information about Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of counseling, health care operations, and payments. **THE LAW REQUIRES** that I obtain your signature acknowledging that I have provided you with this information at the end of this session. When you sign our office contract, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

AA&C, LLC. respects client's confidentiality and will only release information about you in accordance with applicable State and Federal Law. If State Law is stricter, these more stringent provisions will always take precedence. This notice describes our policies related to the use of your mental health records.

AA&C, LLC. is required by law to maintain the privacy of protected health information and to provide you with notice of your legal duties and privacy practices. In accordance with state and federal law, we will make reasonable efforts to limit use, disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose.

LIMITS ON CONFIDENTALITY

The law protects the privacy of all counseling communications between a client and a counselor. In most situations, AA&C, LLC. can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. You should be aware that professionals employed at AA&C, LLC. work with other mental health professionals and administrative staff. In most cases, professionals employed at AA&C, LLC. may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without AA&C, LLC.'s permission.

However, there are some situations where I am permitted and/or required to disclose information without either your consent or authorization:

- ✓ If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information without your (or your personal legal representative's) written authorization, or a court order.
- ✓ If a client files a complaint and/or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

INFORMATION DISCLOSED WITHOUT YOUR CONTSENT

Under Federal Law, information about you can be disclosed without your consent in the following circumstances (certain records, such as drug and alcohol records, are subject to additional disclosure restrictions):

- ✓ EMERGENCIES: In case of an emergency, and if you are not able to give or refuse permission, we will share only the information that is directly necessary for obtaining emergency care for you, according to our professional judgment.
- ✓ DANGER TO SELF AND/OR OTHERS: Information may be disclosed if you are a danger to yourself and/or others. AA&C, LLC. may disclose information to the appropriate authorities if we reasonably believe such disclosure is necessary to protect you or a third party from a clear imminent risk of serious physical and/or mental injury or disease or death. AA&C, LLC. may report information in the event of a serious threat of physical violence against a reasonably identifiable victim.
- ✓ ABUSE AND/OR NEGLECT: Information about you may be disclosed if AA&C, LLC. has a reasonable basis to believe that abuse and/or neglect may have occurred, whether it is child abuse, institutional abuse, and/or domestic violence.
- ✓ AS REQUIRED BY LAW: AA&C, LLC. must disclose information if required to do so by a court order.
- ✓ PUBLIC HEALTH OVERSIGHT AND ACTIVITIES: Information about you may be disclosed to a public health authority that is authorized by law to collect and/or receive information for the protection of the public.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to provide you care, there are times when AA&C, LLC. will need to share your information with others. This includes the following times under Federal Law:

- ✓ TREATMENT: Information about you may be disclosed for treatment purposes. For example, information may be disclosed to a clinical supervisor, consulting therapist and/or physician or member of a team providing services to provide, coordinate, and/or manage your care.
- ✓ PAYMENT: Information may be used for payment purposes. Information may be used to collect sums and/or receive third party payment for certain mental health services, but disclosure will be limited only to information needed to pursue collection.
- ✓ HEALTHCARE OPERATIONS: Information about you may be used to coordinate healthcare operations. For example, the information may be used in conducting a peer review of services being provided. However, if State Law is more restrictive, your protected health information will be disclosed to a third person and/or billing purposes only to the minimum extent necessary and in accordance with such State Law.

CLINICAL RECORD

You should be aware that, pursuant to HIPAA, our office keeps protected health information about you in two sets of professional records. One set constitutes your CLINCIAL RECORD. It may include information about your reasons for seeking counseling, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for counseling, your progress towards those goals, your medical and social history, your billing records, and any reports that have been sent to anymore, including reports to your insurance carrier. Although, in unusual circumstances that involve danger to yourself and/or to others, we may review your clinical record if you request it in writing. If I refuse your request for access to your records, you have the right of review, which I will discuss with you upon request.

PSYCHOTHERAPY NOTES

In addition, AA&C, LLC. also keeps a set of PSYCHOTHERAPY NOTES. These notes are for AA&C, LLC. professional use and are designed to assist our office staff with treatment. Psychotherapy notes may also contain any particularly sensitive information that you may reveal to me that is not required to be included in your clinical record.

Your psychotherapy notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage or penalize you in any way for your refusal to provide it.

ETHICS
All employees of AA&C, LLC. must maintain an ethical standard. Our job is to respect and help our clients. We only help in ways that we are trained, and we do not meet our personal needs through a counseling relationship. Our staff respects each client's privacy and rights as human beings. The aforementioned summary of such may be requested in entirety if desired. Ethical problems may be reported to the director and/or licensing boards written on the professional's *Statement of Professional Disclosure.*

PATIENT RIGHTS
Patients under 18 years of age are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Due to the importance of privacy in the field of counseling, and often crucial to successful progress, AA&C, LLC. may request agreement from the parents that they consent to give up their access to their child's records. If they agree, I will provide them only with general information regarding the progress of the child and also a summary of their child's treatment when such is completed. Any other communication will require the child's authorization, unless AA&C, LLC. professionals feel that the child is in danger or is a danger to someone else, in which case, AA&C, LLC. professionals will notify the parents of such concern. Before giving parents any information, AA&C, LLC. staff will discuss the matter with the child, if possible, and do their best to handle any objections he/she may have.

YOUR RIGHTS
- ✓ Be treated with respect and without discrimination.
- ✓ Receive services in a physically and emotionally safe environment.
- ✓ Receive services and/or referrals that meet your needs and have the opportunity to participate in your own treatment plan.
- ✓ Refuse services.
- ✓ Have an attorney and/or physician review the records with due notice to AA&C, LLC..
- ✓ Receive an explanation if AA&C, LLC. refuses to provide services.
- ✓ Receive information about treatment plan, progress, and treatment alternatives.
- ✓ Receive an explanation about treatment and potential specific risks.
- ✓ Request a second opinion at client cost or the review of another AA&C, LLC. clinician at no cost.
- ✓ Receive written information regarding fees, policies, and clinician training.
- ✓ Be informed of rights in a language you can understand.
- ✓ To file a complaint about AA&C, LLC. and/or its employees with licensing boards and/or accrediting, organizations.

IF YOU HAVE A COMPLAINT
Anyone who receives services here, and/or anyone interested in the welfare of a client, may make a formal complaint about rules, policies, actions, and/or decisions made or allowed by AA&C, LLC.. **REMEMBER: Such complaints and/or actions will be kept confidential.** You may ask for a complaint form from any AA&C, LLC. staff member. Please complete the form and return it to our office within five business days of the incident. You may request assistance from any professional and/or other person in getting or filling out the form. If anyone attempts to stop you from making a complaint, please contact an AA&C, LLC. staff member. Any complaint filed will NOT result in retaliation and/or refusal of services.

RIGHT TO ACCOUNTING OF DISCLOSURE
You have a right to receive a list of all times that AA&C, LLC. professionals have shared your information for purposes other than treatment, payment, healthcare operations, and other specified exceptions.

You should also be aware that your contract with your health insurance company requires that AA&C, LLC. professionals provide it with information relevant to the services that I provide for you. AA&C, LLC. professionals are required to provide a clinical diagnosis. Therefore, sometimes I am required to provide additional information. In such situations, AA&C, LLC. professionals will make every effort to release only the minimum information about you that is necessary for the purpose requested. **BY SIGNING THIS AGREEMENT, YOU AGREE THAT I CAN PROVIDE REQUESTED INFORMATION TO YOUR CARRIER.**

CONTACTING US
Our office is generally open from 9-5:30 Monday-Friday. *It should be noted that AA&C, LLC. professionals provide extended service hours to ensure that the needs of client's are met.* Occasionally, training, holidays, and/or other activities may alter this schedule. In order to contact us, please call and leave a message on our answering machine which is available at all times, through our voice mail system. Our staff will check our messages frequently and return phone calls at our earliest convenience, usually the same or next day. **IF YOU HAVE AN EMERGENCY, PLEASE CALL 911 AND/OR CONTACT THE EMERGENCY ROOM AT A LOCAL HOSPITAL.**

APPOINTMENTS
Appointments are scheduled to fit your needs as much as our staff is able. Please give at least 24 hours notice if you have to cancel an appointment. You may call and leave a message pertaining to such on our machine voice mail system. *It should be noted that it is the policy of our office to charge the full fee for sessions not cancelled prior to the appointment.* Your regular appointment time will not be held if you miss a session without canceling. Exceptions to these policies may be made in case of unusual circumstances.

IN CASE OF AN ILLNESS
If you and/or your child, or anyone in the waiting room is sick, please cancel your appointment in order to protect the health of all other AA&C, LLC. clients and/or providers. Staff members will cancel appointments if they are ill as well. Our office does our very best to keep everyone at our office healthy by encouraging hand-washing, training staff on infection control, and maintaining a clean environment.

FEES
The fees for service vary depending on the provider and the type of services rendered. You will receive more exact information in the Statement of Professional Disclosure provided by your counselor. AA&C, LLC. is a for-profit organization, and payment is expected at the time of service (unless other arrangements are made.)

RIGHT TO COPY OF PRIVACY NOTICE
You will be provided with a paper copy of this document at the time of your initial appointment.
If you have any questions and/or concerns please do not hesitate to contact our office at:

Alpha Assessment & Counseling, LLC.

409 E. Cherokee Ave.

Enid, OK 73701

580.234.8865

(fax)580.234.8361

Revised 2020

Alpha Assessment and Counseling, LLC.

CLIENT DEMOGRAPHIC SURVEY *Information is required by accrediting source, please answer as completely as possible.*

Culture/Ethnicity:

Asian:		African American:		African American/Caucasian:	
Native American:		Hispanic/Latino:		Caucasian:	

Other:____

Gender: **Age:**____________

Male:		Female:	

Marital Status:

Single:		Married:		Separated:	
Divorced:		Living as Married:		Other:	

Referral Source:

Health Plan/EAP:		Phone Book:	
Former Client:		School System:	
PCP:		Attorney:	

Other:____

Payment Source:

Self Pay:		EAP:	
Medicaid:		Private Insurance:	

Other:____

Student Status:

NonStudent:		Full Time:		Part Time:	

Employment Status:

Unemployed:		Part Time:		Full Time:	

Other Demographics:

Person with Physical Disabilities:	
Person with Hearing Impairment:	
Person with Visual Impairment:	
Person with HIV positive/AIDS:	
Person with Developmental Delay:	
Person with Dual Diagnosis:	
Person with Substance Abuse and/or Other Addications:	

Client Name:____________________________ **Client Identifier #:**__________________

Revised 2020

Client Medication Record

Client Name:______________________________

Name of Medication	Reason for Medication	Dosage	Frequency	Route of Administration

Notes and Client Medication History:____
____
____
____
____
____
____
____

This form was completed by:_________________________ **Date:**_______________

AA&C, LLC. Problem Checklist

The following behavior checklist is to be used regarding individual's which have completed therapeutic services at AA&C, LLC. Please check ONE box for each item to describe how often the client is currently showing each behavior. If the question does not apply check "Never." Please complete and return to our office at 114 East Broadway, Suite 702-Enid, OK 73701. Your responses will help our staff provide clients with effective treatment. Please contact your office if you have further questions. Your time is appreciated.

Client's Name:______________________________ Date:______________

QUESTION	NEVER	ONCE PER YEAR	ONCE EVERY 2 MONTHS	2-3 PER MONTH	ONCE OR MORE PER WEEK	EVERYDAY
Exhibits anxiety (e.g., anxious, fearful) (1)						
Cries/laughs too easily; emotionally labile (1)						
Appears unhappy; depressed (1)						
Stubborn and/or sullen (1)						
Clings to adults/doesn't want to be alone (1)						
Scared or startled easily without good reason, jumpy (1)						
Worried without good reason (1)						
Physical reactions such as headaches, stomach aches, vomiting, other (1)						
Unresponsive to positive statements/behavior from caretakers with smiles, laughter, etc. (1, 5)						
Unduly impulsive (2)						
Uses bizarre speech (2)						
Has excessive and/or preoccupations with objects/activities (2)						
Expresses thoughts that are not sensible (2)						
Appears to be attending and/or responding to internal stimuli (e.g., possible visual and/or auditory hallucinations) (2)						
Unaware of happenings in immediate environment (2)						
Inability to follow simple instructions (2)						
Unresponsive to redirection by caregivers (2)						
Exhibits facial/body tics (4)						
Pulls-out hair (e.g., eyebrows, head) (4)						
Grinds teeth (4)						
Exhibits peculiar mannerisms/habits; stereotypical						

behavior (4)						
QUESTION	**NEVER**	**ONCE PER YEAR**	**ONCE EVERY 2 MONTHS**	**2-3 PER MONTH**	**ONCE OR MORE PER WEEK**	**EVERYDAY**
Rocks back and forth when sitting/standing (4)						
Incontinent for urine and/or feces (4, 9)						
Sleeping on floor (4, 9)						
Eating difficulties (4, 9)						
Sleep disturbances (4, 9)						
Difficulty falling and/or staying asleep (4, 9)						
Night terrors (4, 9)						
Reoccurring nightmares and/or bad dreams (4, 9)						
Does not allow anyone to touch; tactile defensiveness (5, 6)						
Clothing articles bother client (e.g., tags, socks, pants, etc.) (4)						
Unable to recognize the rewarding aspects of human contact (5, 6)						
Does not respond to presence of familiar caretakers; minimal attachment and/or bonding behavior (5, 6)						
Withdraws from contact with others; isolates (6)						
Poor eye contact (6)						
Refuses scheduled activities (7)						
Overly active (7)						
Refuses work assignments (7)						
Has temper tantrums (8)						
Negativistic and/or defiant (8)						
Teases and/or bullies others (8)						
Shows a lack of consideration for others (8)						
Lies, cheats, steals (8)						
Physically and/or verbally aggressive towards others (8)						
Runs away if not supervised (8)						
Removes clothing in inappropriate places (8)						
Engages in inappropriate sexual behavior (8)						
Displays self abuse and/or self-injurious behavior (8)						
Intentionally destroys property of own and/or others (8)						
Makes no effort to communicate needs (9)						

You may describe and/or list any further concerns in the space below if desired: ______________________

____

____

FOR OFFICE USE ONLY	FOLLOW-UP SURVEY SENT: YES/NO DATE:

Client ID#:______________________

CLIENT CONSENT FOR TREATMENT

I/We (parent, legal guardian if applicable) authorize Alpha Assessment & Counseling to administer treatment and to continue such treatment as deemed necessary.

I/We hereby authorize counseling and psychological services by any physician, therapist, mental health professional and/or behavioral health rehabilitation specialist authorized by Alpha Assessment & Counseling

I/We understand that this consent is given before any specific diagnosis or treatment is required, but is given to authorize Alpha Assessment & Counseling the ability to exercise their judgment in providing treatment.

I/We agree to be actively involved in the treatment plan as prescribed by Alpha Assessment & Counseling during the period of treatment.

I/We understand that included in this treatment plan will be noted our involvement in regular individual, family, and/or group therapy sessions.

I/We consent to being contacted after discharge for the purpose of obtaining information in effect to improve the quality of care (e.g. client satisfaction surveys, etc.).

I/We understand that no guarantees have been given by anyone as to the results that may be obtained through counseling and other related services.

I/We understand that I/We have the right to request a change in the counselor we are assigned through completion of the Request to Change Counselor form.

I/We understand that alternative treatment options exist and that I/We may choose to seek other options. If such a decision is made, I/We agree to discuss the decision with our assigned counselor.

I/We agree that my/our services will be discharged at the discretion of the Alpha Assessment & Counseling staff and/or referring agency upon completion of all treatment plan goals and objectives.

I/We shall exhibit alleviated or eliminated symptoms as indicated in the individualized treatment plan with a return to normal level of functioning in my/our environment.

This consent shall remain in effect commencing on the date of admission until the client has been discharged and for the purposes of follow up, unless revoked in writing and delivered to Alpha Assessment & Counseling

Client Signature:_______________________________________ **Date:**______________________

Parent/Legal Guardian Signature:__________________________ **Date:**______________________

Provider Signature:_____________________________________ **Date:**______________________

Client Name:_______________________________ **Client Identifier #:**__________________

CLIENT PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL, MENTAL HEALTH, ALCOHOL AND OTHER DRUG RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW THIS CAREFULLY.***

Information about your health care, including payment, is protected by State and Federal Law[1]. Under these laws, Alpha Assessment & Counseling, LLC. may not say to any person outside Alpha Assessment & Counseling that you receive services from us without your consent. In most cases, ALPHA ASSESSMENT & COUNSELING must get your written consent before we can release information about you.

EXAMPLE: *We must get your written consent before we can release information to your health insurer for payment.*

You may cancel your consent in writing at any time. You cannot cancel consent for information that has already been released.

Federal law allows us to release information without your written permission:

1. If ALPHA ASSESSMENT & COUNSELING has an agreement with an outside organization known as a qualified service organization or business associate to provide services to clients;
2. For research, audit or evaluations;
3. To report a crime committed on ALPHA ASSESSMENT & COUNSELING property or against ALPHA ASSESSMENT & COUNSELING staff;
4. To medical personnel in a medical emergency;
5. To report suspected child or elder abuse or neglect; or
6. As allowed by a court order.

EXAMPLE: *ALPHA ASSESSMENT & COUNSELING can release information without your consent to an outside organization that provides services to ALPHA ASSESSMENT & COUNSELING or to our clients, such as data processing, laboratory, or financial services or to another medical facility to provide healthcare to you, as long as we have a proper business associate/qualified service organization agreement in place.*

Request Restriction --You may ask us to limit certain uses or disclosure of your health information. ALPHA ASSESSMENT & COUNSELING will consider your request, but does not have to agree. If your request is granted, ALPHA ASSESSMENT & COUNSELING will comply except in emergency situations. We cannot agree to limit uses or releases that are required by law.

Request Confidential Communications --You may let us know how and where you would like to be contacted. For example, you can ask that we contact you by phone rather than mail or at work rather than home. Your request must be in writing. We will go along with reasonable requests. We will not ask you for a reason.

Inspect and Copy --In most cases, you have the right to see or get copies of your records. You must make your request in writing using the "ALPHA ASSESSMENT & COUNSELING Consent for Release of Confidential Information" form. You may be charged for copies of your records.

Amend/Correct --You may ask us to change information in your records if you think there is a mistake. However, we will not erase the original information. You must make a written request that explains your reason(s). We do not have to agree to your request for changes if we determine, among other things, that the current information is correct and complete.

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[1] The Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 U.S.C. § 1320d et seq., 45 C.F.R. Parts 160 and 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2.

An Accounting of Disclosures --You may ask for a list of persons to whom your health information has been released. The first list will be free. We may charge for additional lists. We will tell you about any charges and allow you to withdraw or change your request.

A Paper Copy of this Notice --You may ask us for a copy of this notice at any time. State and Federal laws require ALPHA ASSESSMENT & COUNSELING to keep your health information private and to give you this notice of our legal duties and privacy practices.

By law, we will follow the terms of this notice. ALPHA ASSESSMENT & COUNSELING has the right to change this notice. Any changes will apply to information we already have about you, as well as any future information. The notice contains an effective date (Notice of Privacy Act, April 2003). We will post a copy of the current notice in our facility we will offer you the current notice each time you are admitted.

You may complain to ALPHA ASSESSMENT & COUNSELING, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services, and/or the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated under state or federal law. You will not be penalized for filing a complaint.

To file a complaint with the Oklahoma Department of Mental Health and Substance Abuse Services contact:

Office of Consumer Advocacy
2000 N. Classen Blvd.
Ste. E600
Oklahoma City, OK 73106

If you have any questions about this notice or our privacy practices, please contact our Executive Director, Shaye Reilly, LPC., NCC. who serves as the Privacy Officer of ALPHA ASSESSMENT & COUNSELING, at (580) 234-8865.

Violation of confidentiality laws by ALPHA ASSESSMENT & COUNSELING is a crime. Suspected violations of the confidentiality law may be reported to the United States Attorney.

Client Signature:______________________________ **Date:**________________

Parent/Legal Guardian Signature:______________________ **Date:**________________

Provider Signature:____________________________ **Date:**________________

CLIENT BILL OF RIGHTS

Programs providing treatment or services without the physical custody or detention of clients shall support and protect the fundamental human, civil, and constitutional rights of the individual client. Each client has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

(1) Each client shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
(2) Each client has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
(3) No client shall be neglected or sexually, physically, verbally, or otherwise abused.
(4) Each client shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A client shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those clients adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. If the client permits, family shall be involved.
(5) Every client's record shall be treated in a confidential manner.
(6) No client shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the client.
(7) A client shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
(8) Each client has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
(9) No client shall be retaliated against or subjected to any adverse change of conditions or treatment because the client asserted his or her rights.

If you have questions concerning these rights or wish to file a complaint or grievance, please contact the Oklahoma Department of Mental Health and Substance Abuse Services, Division of Consumer Advocacy, 2000 N. Classen Blvd. Ste. E600, Oklahoma, OK 73706, OKC Metro: 405.248.9037 or Statewide: 1-866-699-6605 E-mail: advocacydivision@odmhsas.org

Please sign below to acknowledge receipt:

Client Signature:____________________ **Date:**____________

Parent/Legal Guardian Signature:____________________ **Date:**____________

Provider Signature:____________________ **Date:**____________

Client Name:____________________ **Client Identifier #:**____________

CLIENT WRITTEN NOTICE OF GRIEVANCE POLICY AND PROCEDURES

ETHICS

All employees of Alpha Assessment and Counseling, LLC. must maintain a high ethical standard. Our job is to respect and help our clients. It shall be the responsibility of Licensed Professional , in their commitment to the understanding of human behavior, value objectivity and integrity, and in providing services, to strive to maintain the highest standards of their profession. LPCs shall accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately. LPCs shall be alert to personal, social, organizational, financial, and political situations or pressures that might lead to the misuse of their influence. LPCs shall not participate in, condone, or be associated with dishonesty, fraud, deceit or misrepresentation. LPCs shall not exploit their relationships with clients for personal advantage, profit, satisfaction, or interest.
[**Source:** Amended at 13 Ok Reg 2495, eff 6-27-96; Amended at 16 Ok Reg 2499, eff 6-25-99]
We only help in ways that we are trained, and we do not meet our personal needs through a counseling relationship. Our staff respects each client's privacy and rights as human beings. The aforementioned summary of such may be requested in entirety if desired. Ethical problems may be reported to the director and/or licensing boards written on the professional's *Statement of Professional Disclosure* and/or by the information listed under the Professional Counselor Licensing Division. To file a complaint with the Oklahoma Department of Mental Health and Substance Abuse, please note the following contact information provided below.

Professional Counselor Licensing Division
1000 N.E. 10th Street
Oklahoma City, OK 73117-1299
(405) 271-6030, FAX (405) 271-1918

Oklahoma Department of Mental Health and Substance Abuse Services
Office of Consumer Advocacy
2000 N. Classen Blvd.
Ste. E600
Oklahoma City, OK 73106

IF YOU HAVE A COMPLAINT

Anyone who receives services here, and/or anyone interested in the welfare of a client, may make a formal complaint about rules, policies, actions, and/or decisions made or allowed by Alpha Assessment and Counseling, LLC. **REMEMBER: Such complaints and/or actions will be kept confidential.** You may ask for a complaint form from any Alpha Assessment and Counseling, LLC. staff member. You may request assistance from any professional and/or other person in getting and/or filling out the form. If anyone attempts to stop you from making a complaint, please contact an Alpha Assessment and Counseling, LLC. owner and Executive Director, Shaye Sheppard-Aman, M.Ed., MCP., LPC., NCC. Any complaint filed will NOT result in retaliation and/or refusal of services.

Please sign below to acknowledge receipt:

Client Signature:______________________________ **Date:**__________________

Parent/Legal Guardian Signature:______________________ **Date:**__________________

Provider Signature:_____________________________ **Date:**__________________

Client Name:__________________________ **Client Identifier #:**__________________

Alpha Assessment and Counseling, LLC.

CLIENT CONSENT FOR FOLLOW-UP

I, ____ authorize
(Name of Person Receiving Services)
_________________________________to contact me by telephone at the
(Name of counselor or designated staff)

following number(s):____; by mail at the

following address:____; and/or by

email at:____

after I have completed services at Alpha Assessment & Counseling. I understand the following:

- My participation is voluntary.
- If I agree to participate, I will be asked to verify my identity if the staff person identified above contacts me by telephone. There is always the potential risk that other persons with access to my telephone number or e-mail may find out about my participation in Alpha Assessment & Counseling services.
- I may withdraw my consent and discontinue participation any time without prejudice to my future services, except to the extent that action has been taken in reliance on it.

This consent shall remain in effect commencing on the date of signature and expire one year post signature date, unless revoked in writing and delivered to Alpha Assessment & Counseling.

I understand the information provided and I was given an opportunity to ask questions and all my questions were answered to my satisfaction, and I was given a copy of this form.

Client Signature:___________________________________ **Date:**____________________

Parent/Legal Guardian Signature:_______________________ **Date:**____________________

I have explained the protocol to the client and answered all of her/his questions. I believe that she/he understands the information described in this document and freely consents to participate.

Provider Signature:_________________________________ **Date:**____________________

Client Name:___________________________ **Client Identifier #:**____________________

Revised 2020

Contract for Policy and Procedures

I have read or someone has read to me the policies in the pamphlet "Information for New Clients." An Alpha Assessment & Counseling, LLC. staff member has satisfactorily answered all my questions about these policies & procedures and I have received the pamphlet to take home with me today. I checked each policy & procedure below on ______________ to signify my understanding.
(DATE)

Please check the boxes below that apply:

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s orientation and HIPPAA procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s client consent for treatment procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s privacy and confidentiality procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s client bill of rights procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s appointment procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s contacting Alpha Assessment and Counseling, LLC. staff/providers procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s ethics procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s client grivence/complaint procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s client consent for follow-up procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s client request to change Counselor procedure.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC.'s insurance procedures.

[ ] I reviewed and/or was given a copy of Alpha Assessment and Counseling, LLC's sliding fee scale.

Client Signature:______________________________________ **Date:**____________________

Parent/Legal Guardian Signature:________________________ **Date:**____________________

Provider Signature:____________________________________ **Date:**____________________

Client Name:____________________________ **Client Identifier #:**____________________

INSURANCE INFORMATION FORM

__________ **I DO** give my permission for Alpha Assessment and Counseling, LLC. to bill my insurance company for services rendered. I give permission for all insurance and/or Employee Assistance Program payments for AA&C services to be paid directly to this office. I also give permission to release to my insurance company and/or Employee Assistance Program any diagnostic or treatment information they request.

__________ **I DO NOT** give my permission for Alpha Assessment and Counseling, LLC. to bill my insurance company for services rendered. I understand that I am responsible for services rendered.

__________ **I DO NOT** have insurance. I understand that I am responsible for services rendered by Alpha Assessment and Counseling, LLC.

Client Name (please print):____

Client Signature (if 14 years or older):______________________________________

Client Legal Guardian:____

Date:____

Client Name:______________________________ **Client Identifier #:**________________

Alpha Assessment and Counseling, LLC.

Client Name:____ Date: ____________________

Alpha Assessment & Counseling, LLC. can determine fees for services based on an income sensitive sliding scale. If you believe that this service would benefit you, please complete the financial information requested below. Your fees can be based on the information you provide and conversation that you have with your provider. Please include your total monthly gross (before taxes) income from all sources and/or provide garnishment information if applicable.

Gross monthly income for self	$
Gross monthly income for spouse/partner	$
Other household income this month	$
Total Monthly Income	$
Total income past 12 months	$
Number of persons dependent on above income	
Other Information (e.g., garnishments, etc.)	

Please read the following carefully and ask a staff member if you have questions:

- I understand that I am responsible for the cost of all services received at Alpha Assessment and Counseling, LLC.
- If insured, I understand that I am responsible for the cost of the co-payment and/or any unpaid balance after your insurer provides payment to Alpha Assessment and Counseling, LCC.
- I understand that if I fail to keep an appointment for any type of session (class, group, or individual), this will be considered a "No Show," and I will be expected to pay the total amount for that session.
- Insurance will not pay for missed appointments.
- An unpaid balance will be sent to collection after 60 days.
- I understand that a counseling 'hour' is considered to have lapsed in 50 minutes; a half hour session is 25 minutes. Fees are figured to the nearest quarter hour.
- I understand that if I am court ordered or required to complete a treatment program at Alpha Assessment & Counseling, all fees must be paid in order to complete the program.

The charges for my services at Alpha Assessment & Counseling, LLC. per session will be $100.00.

Your signature signifies you understand that you are responsible for payment of any co-payments, deductibles or self-pay fees at the time services are rendered. If the service is not covered by your insurer, you assume responsibility for the payment of fees. Your behavioral health insurance plan determines your co-pay and any deductable.

I have read, understand, and agree to this fee agreement.

Client Signature:________________________________ **Date:**____________________

Parent/Legal Guardian Signature:______________________ **Date:**____________________

Provider Signature:________________________________ **Date:**____________________

Client ID#:____________________

REQUEST TO CHANGE COUNSELOR FORM

For many people, therapy is a treatment of last resort. Because therapy patients often view therapy as a panacea and one, which they'll only try when life gets impossible, so the disappointment you feel when therapy doesn't work can be discouraging. Mental illness is just like any other health condition, though. Whether it's difficulty coping with stress or something more serious, such as post-traumatic stress disorder, the first treatment doesn't always work. If therapy has failed you, you still have plenty of options for feeling better.

If therapy isn't working, the first person you should talk to is your therapist. He/She may opt to change her approach to treatment, pursue more "homework" options for you, or even refer you to another counselor.
Or what if you like your therapist but therapy's just not going where you want it? It's not enough to like your therapist, and there's a huge differences in technique from therapist to therapist. If therapy's not working, consider whether your therapist is the right one for you.

Trust us, we've been "fired" before and we've survived. We completely understand that each consumer has specific needs and it is the goal of our agency to ensure the best possible services for your therapeutic journey.

TALK TO YOUR COUNSELOR

If you're struggling with getting what you need out of your counseling sessions, speak to your counselor. Discuss specific needs and treatment goals. Your counselor and you can work together to find you the best fit for your needs.

______________________________	______________
Client Signature	Date
______________________________	______________
Parent/Legal Guardian Signature	Date
______________________________	______________
Provider Signature	Date
______________________________	______________
Client Name	Client Identification #

Revised 2020

Alpha Assessment & Counseling, LLC.
Case Management Screening Form

Complete the following screening information to determine the client's need for case management services. All clients shall receive a screening for case management. If found appropriate, case management goals/objectives/referrals will be added to the master treatment plan as an addendum.

Client Name	Date

1. Are you currently employed?... Yes__ No__

   If no, what are your job skills or interests? ______________________________________

   ____

2. Do you have housing?.. Yes__ No__

   If no, do you need assistance locating housing?______________________________

3. Do you currently use substances?... Yes__ No__

   What type/frequency:____

4. Do you need assistance with medical or health issues?... Yes__ No__

   If so, what type?____

5. Do you have any needs or problems you would like assistance with?...................... Yes__ No__

   If yes, in what areas:____

   ____

6. Do you have strengths, resources or a support system in your life?...................... Yes__ No__

   If yes, in what areas:____

   ____

7. Would you like to receive case management services?... Yes__ No__

I would like to receive case management services from Alpha Assessment & Counseling, LLC. I understand the elements of case management and have participated in the development of my goals and objectives. I understand that I will receive case management services at the frequency of _____time(s) per month.

Client Signature:____ Date:______________________

Staff Signature: ____ Date: ______________________

Client ID#:___________________________

Case Management Plan Addendum

(Goals in the Client's Words)

Goal #1: ______________________________

Objective: 1a: ______________________________

Objective: 1b: ______________________________

Objective: 1c: ______________________________

Goal #2: ______________________________

Objective: 2a: ______________________________

Objective: 2b: ______________________________

Objective: 2c: ______________________________

Goal #3: ______________________________

Objective: 3a: ______________________________

Objective: 3b: ______________________________

Objective: 3c: ______________________________

I, ______________________________, have participated in the development of my Case Management treatment plan addendum. I agree with this plan.

______________________________ ______________________________
Client (or authorized Rep) Signature Date

______________________________ ______________________________
Parent and/or Legal Guardian Signature Date

______________________________ ______________________________
Provider Signature and Credentials Date

Client ID#: ______________________________