WHERE FAMILIES COME FIRST

Desert View

FAMILY COUNSELING SERVICES

Welcome to Desert View Family Counseling Services

Please note that this information is important for your care. Please fill out forms as completely as possible.

ADULT INTAKE FORM (ages 18+)

Please PRINT all information

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

What is your gender identity? ☐ Male ☐ Female ☐ Transgender ☐ Gender Non-Conforming

What sex were you assigned at birth? ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Other

Address (mailing): _____

City, State, Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Are you a veteran? ☐ YES ☐ NO SS#: _____

Race: ☐ Native America or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____

Preferred Language: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

REFERRAL SOURCE

	SELF		FAMILY
	SCHOOL		TRIBAL SOCIAL SERVICE
	COURT (please list Judge's name)		
	PROBATION (PO's name)		
	MEDICAL DOCTOR (Doctor's name)		
	DWI FACILITY		CYFD
	POLICE DEPT.		FRIEND
	OTHER (please explain)		

EMERGENCY CONTACT

Contact Name: _____Relationship to Patient: _____

Address: _____ Phone: _____

EMPLOYMENT STATUS

☐ Full-Time (35+ hours) ☐ Part-Time ☐ Not Working

Occupation: _____

Employer: _____ Phone: _____

CLIENTS LIVING ARRANGMENT

	Lives in own home		Owns home (mortgage)		Unstable
	Lives in an apartment		Rent		Homeless – Currently
	Lives with parents		Other:		Homeless – Past
	Lives with friends		Stable		Lives in Shelter

HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc.)	Age	Sex	Type (bio, step, etc.)	Living with you? Y/N

If additional space is needed, please list on last blank page.

PLEASE CHECK OTHER PROBLEM AREAS FOR WHICH YOU ARE SEEKING HELP:

	Abused as Child		Depression		Marital Conflicts
	Adult Victim/ Witness DV		Divorce		Mood Swings
	Aggression / Violence		Drug Abuse		Obsessions
	Alcohol Abuse		Eating Problems		Physical Abuse
	Anger Problems		Excessive Stress		Problems with Law / Courts
	Anxiety		Fighting		Self-esteem
	Behavioral Problems		Grief		Sexual Abuse
	Childhood Issues		Homeless		Sleep Problems
	Codependence		Hyperactivity		Suicidal Thoughts / Actions
	Defiance		Impluse Control Problems		Work Problems

What is your main concern at this time? _____

Have you ever been charged with a sex crime? _____

Have you ever been charged with battery or domestic violence?_____

PAST COUNSELING HISTORY

Have you previously seen a counselor? ☐ YES ☐ NO

Have you had a mental health assessment in the last year? ☐ YES ☐ NO

If yes (to either question), please answer the next questions.

Who did you see? _____

Where did you have treatment? _____

When were you seen? _____

What was the diagnosis? _____

An **ADVANCE DIRECTIVE** is a written document that describes what a person wants to happen if at some time in the future they are judged to be unable to decide for themselves or they are unable to communicate effectively. It often names a person to whom they have given authority to make those mental health decisions on their behalf. It also can inform providers what treatment they do or do not want.

Do you have an ADVANCE DIRECTIVE? ☐ YES ☐ NO

Would you like information about an advance directive? ☐ YES ☐ NO

You have the right to private, confidential communication with the doctor, therapist, and treatment team providing your care. This means that some of the issues that you discuss will stay between you and your treatment provider, and we will not disclose that information to anyone, including your partner/spouse, unless we have been given permission by you to do so. We need you to be open and honest with us in order to understand and treat the full range of issues you are dealing with. We will always encourage honesty. We will encourage, prepare and support you until you feel safe enough to share those issues.

According to the State of New Mexico, and the federal patient privacy law known as HIPPA, you will need to give your consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of age.
- Any information that your provider believes, if released, could cause harm to you or to someone else, or that would significantly harm the treatment relationship.
- You should know that this confidentiality has limit. If there is any threat to you, we have the duty to inform the proper authorities and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.

CONFIDENTIALITY

Confidentiality means that Desert View Family Counseling has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your written consent. In such situations, Desert View Family Counseling is not required to inform you of these actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without a minor's consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

The information that I have provided is, to the best of my ability, correct and true. I have also read and understand the statements within this packet.

_____ _____

Client Signature Date

HEALTH SUMMARY

DO YOU HAVE A PRIMARY CARE PHYSICIAN (PCP)? NAME:_____

DO YOU WISH FOR YOUR PCP TO BE NOTIFIED THAT YOU ARE RECEIVING SERVICES AT THE DESERT VIEW? **IF YES, PLEASE COMPLETE THE NEXT PAGE.** YES_____ NO_____

IF NO PCP, WHERE DO YOU MEET YOUR HEALTH NEEDS WHEN NECESSARY?

_____

PLEASE LIST ANY CURRENT HEALTH CONCERNS AND RELATED TREATMENT (include any special health needs):

_____

_____

DO YOU HAVE A PSYCHIATRIST? YES____ NO_____ IF YES, NAME:_____

DO YOU SUFFER FROM ANY CURRENT OR CHRONIC PAIN (including headaches)? HOW DO YOU TREAT THIS PAIN?

_____

_____

DO YOU HAVE A HISTORY OF HEAD TRAUMA (describe)?_____

DO YOU HAVE A HISTORY OF SEIZURES (describe)? _____

HAVE YOU EVER BEEN UNCONSCIOUS FOR ANY REASON (describe)?

_____

_____

LIST ALL MEDICATIONS CURRENTLY BEING USED AND DOSAGE:

_____

_____

LIST ALL ALLERGIES OR SENSITIVITIES TO PHARMACEUTICALS AND/OR OTHER SUBSTANCES:

_____

_____

DO YOU SMOKE CIGARETTES? YES____ NO___ IF YES HOW MANY PER DAY? _____

DO YOU USE ANY ALCOHOL? YES___ NO___ IF YES, HOW MANY DRINKS/HOW OFTEN?_____

DO YOU USE ANY ILLICIT/STREET DRUGS? YES____ NO____ IF YES, WHICH ONE(S)/HOW OFTEN?

_____

OFFICE USE ONLY: ADMINISTER SASSI? YES NO DATE OF ADMINISTRATION:_____

PHYSICIAN NOTICE AND RELEASE OF INFORMATION

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

_____ _____
Name of MD Client Name

_____ _____
Address of MD DOB

_____
City, State and zip of MD

Presenting Problem(s):_____
Proposed Service Plan:_____

The client named below is receiving psychotherapy at Desert View Family Counseling. The client has indicated that you are the primary physician _____ or psychiatrist_____.

The client has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client.

If you wish to contact me, please call (505) 326-7878.

Thank you.

_____
Therapist

I_____ authorize _____ (do not authorize _____) that this
Print Your Name

notice be sent to the above named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

_____ Date _____
Signature of patient or guardian of minor.

CONSENT TO TREAT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Desert View Family Counseling. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. Probable consequences of not receiving treatment

2. **Clinical Supervision**: Your case may be staffed with the clinical director and/or other licensed therapist within the agency. This is to ensure the best possible outcome for you and your family.

3. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Desert View Family Counseling, and I consent to disclosure for use by Desert View Family Counseling staff for the purpose of continuity of my care. Per New Mexico mental health law, information provided will be kept confidential with the following exceptions: 1) if it is deemed that I present a danger to myself or others; 2) if concerns about possible abuse arise from an intimate partner or household member; or 3) if a court order is issued to obtain records.

4. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

5. **Sessions** are between 45 and 50 minutes long.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

7. **Desert View Family Counseling reserves the right to refuse service to anyone.**

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself. I understand that I have the right to ask questions to my service provider about the above information at any time.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if patient is under 18) Date

_____ _____
Signature of witness Date

NO SHOW OR LATE CANCEL APPOINTMENT FEE NOTICE

Any patient who shows up 15 minutes late or more to their scheduled appointment will be rescheduled.

We understand that occasionally missed appointments can occur for a variety of reasons.

**However, when you miss an appointment without canceling,
someone else who could have been seen in your place is delayed unnecessarily.
We track missed (non-canceled) appointments.**

A "No Show / Late Cancellation" is defined as missing an appointments without canceling 24 hours in advance.

Insurance will not cover charges for no show / late cancellation fees. A $35.00 charge will be placed on each patient (2 siblings scheduled, 2 no show charges, etc.) account and billed to the responsible party. Please be aware multiple offenses may result in being discharged from our practice.

**Please sign and state that you are aware of and understand our policy.
Thank you, Desert View Family Counseling**

_____ _____

Signature **Date**

CLIENT RIGHTS & RESPONSIBILTIES

PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING A DESERT VIEW THERAPIST

Clients have the right to:

- receive humane care and treatment, with respect and consideration
- privacy and confidentiality when seeking or receiving care except for life threatening situations or conditions
- confidentiality of your health records
- receive accurate information concerning diagnosis and treatment,
- a second professional opinion regarding diagnosis or treatment
- participate actively in decisions regarding one's mental healthcare and treatment
- accessible information regarding the scope and availability of services
- be informed about any legal reporting requirements regarding any aspect of screening or treatment
- a copy of your mental health record upon request and written authorization
- file a complaint with the director of Desert View Family Counseling regarding any concerns related to the privacy, confidentiality or security of your record
- review and amend your record
- revoke your authorization to release except to the extent that action has not already been taken
- a copy of any fees and charges related to your visit

Clients have a responsibility to:

- provide complete information about one's mental health problem, to enable proper evaluation and treatment
- ask questions to ensure an understanding of the condition or problem
- show respect to Desert View Family Counseling personnel and other clients
- reschedule/cancel an appointment within 24 hours so another person may see a therapist
- pay bills or file health claims in a timely manner
- provide requests for permission to release health records in writing to Desert View Family Counseling

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING

I have read and accept this agreement and herewith consent to counseling/psychotherapy treatment with Desert View Family Counseling.

_____ _____

Client Signature or Parent/Guardian (if under 18) Date

Counseling Fee Financial Agreement

The following is a fee agreement. Please read carefully before signing and ask for clarification on any portion that you do not understand. Please initial after each statement indicating that you understand and agree to the statement:

1. **I agree to pay all fees** at the time of service.: _____ (initial)

2. **Cancellation and no show policy (only initial the one that applies to your situation)**:

    a. (**Commercial Insurance and Self Pay Clients**): There will be no charge if appointments are cancelled 24 hours in advance. Cancellations made on the same day of appointment are subject to late cancellation fee. A $35 fee will be applied to each no show or late cancellations and must be paid prior to scheduling the next appointment. After two no shows/late cancellations and /or excessive cancellations, clients may be discharged. _____ (initial)

    b. (**Medicaid Clients**): After two no show / no calls or late cancellations, you will be discharged with the option of being referred to another counseling agency of your choice. _____ (initial)

3. I understand that while Desert View Family Counseling does send out reminder calls and/or texts as a courtesy. I am responsible for keeping appointments that have been made, regardless of whether I receive a reminder or not. _____(initial)

4. Desert View does bill **insurance companies** however you are responsible for all co-pays, deductible, agency fees, and any unpaid or denied claims by your insurance company. _____ (initial)

5. If my account is turned over to collections for non-payment, I will be responsible for up to an additional 33% of my original balance. _____(initial)

6. **Sliding scale:** It is the mission of The Desert View Family Counseling Services to provide our services to all eligible individuals. Please ask about our sliding scale if you are unable to make full payment at this time. If your financial work sheet determines you may be **eligible for assistance, you will still be responsible for all co pays (if applicable) and all agency fees. PROOF of Income** is required for funding assistance _____ (initial)

7. I understand if my services are covered by a grant and the grant becomes depleted, I will be responsible for services and payment will be due at the time of service. _____ (initial)

I have read the above agreement and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

Please keep a copy for your records.

Responsible Party Signature: _____ **Date**: _____

Witness: _____ **Date**: _____

Grievance Policy

A BILL OF CLIENT'S RIGHTS has been provided and signed by you. If you feel your Case Manager or Therapist has violated any of these rights, you have the right to express your grievance, and appropriate action will be taken to remedy the situation.

STEP ONE:

Submit a completed grievance form to the Executive Director, in a sealed envelope, marked CONFIDENTIAL. You may obtain the grievance form and envelope from the Desert View office staff.

STEP TWO:

The Executive Director will conduct an investigation to determine the facts of the case, complete a report within 10 business days of the receipt of the grievance.

STEP THREE:

Within 10 business days of the receipt of the report, the Executive Director will inform the client, in writing, of the decision, and the reason for the decision regarding the reported incident.

I acknowledge that I have received a copy of Desert View's grievance procedure, and that I fully understand the contents of the document.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Insurance / Grant and / or Sliding Fee Scale Form
Information is needed to bill your insurance!
CLIENT MUST HAVE SUPPORTING FINANCIAL DOCUMENTATION TO QUALIFY

Patient Information			**Today's Date:** / /
First Name:	Middle:	Last:	Other names:

Responsible Party Information (usually parent/guardian) □ **Same as patient**			**Today's Date:** / /
First Name:	Middle:	Last:	Other names:
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes	No

Insurance Information (Please provide your Insurance Card to DVFC)					
Insurance Company		ID#		Group #	
Subscriber Full Name		DOB		Relationship	
Gender		**All information is necessary to bill insurance companies. Lack of information could cause a claim rejection and you to become responsible for the fee.**			
Subscriber SSN					

Monthly Expenses					
Rent/Mortgage		Medical Bills		Car Loan	
Food		Utilities		Car Insurance	
Student Loans		Other		**TOTAL** will be calculated by billing	

Household Size		
Name	**Date of Birth**	**Relationship to Patient**
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence.

You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof.

TOTAL	$	Weekly Monthly Yearly			
Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child, Support, Alimony					
Other					
				TOTAL	**$**

It is your responsibility to keep us updated of your most current financial and insurance information.

Other Questions for Grant Funding

Are you disabled? □ YES □ NO

Are you a veteran of the US Armed Forces? □ YES □ NO

Are you pregnant? □ YES □ NO

I hereby confirm the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment.

I further agree to inform ***Desert View Family Counseling Services*** if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Desert View Family Counseling Services.

I hereby acknowledge that I read the foregoing disclosure and understand it.

Responsible Party Signature: _____ _____
Date

(THIS SECTION FOR OFFICE USE ONLY)

Applicant □ APPROVED or □ DENIED for financial hardship assistance.

Grant _____ Secondary Funding _____

Agency Fee for each visit _____

Authorized Case Manager Signature: _____Date_____