**Initial Intake Form**

Please complete this form in entirety and *email*, place in the *office* OR *mailbox* of:

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Clients Name  | DOB  | Person Making Referral |
|  |  |  |

**Apparent problem** (check all that apply):

\_\_\_\_ Physical Health Problem (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Difficulty in Making a Transition

\_\_\_ Newcomer having trouble with school adjustment \_\_\_ Trouble adjusting to new program \_\_\_ Other

\_\_\_\_ Social Problems

\_\_\_ Aggressive \_\_\_ Shy \_\_\_Overactive \_\_\_ Unmotivated \_\_\_ Other \_\_\_\_\_\_­­­­\_\_\_

 **Mental Health Concern:**

\_\_\_ Self-esteem \_\_\_ Relationship problems \_\_\_ Grief \_\_\_ Hunger

\_\_\_ Depression/suicide \_\_\_ Physical/sexual abuse \_\_\_ Anxiety/Phobia \_\_ Neglect \_\_\_ Disabilities \_\_\_ Bullying \_\_\_Teasing/Teased \_\_\_ Chronic illness \_\_\_ Trauma \_\_\_ Anger \_\_\_ Other: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_

**Other Specific Concerns:**

|  |
| --- |
|  |
|  |

**Current school functioning and desire for assistance.**

Overall Academic Performance

\_\_\_ Above grade level \_\_\_ at grade level \_\_\_slightly below grade level \_\_\_well below grade level

Notes:

Chief Complaint:

Current Symptoms:

Stressors:

**Community Information**

|  |  |  |
| --- | --- | --- |
| School  | Contact Person | Phone and Address |
|  |  |  |
| Primary Care Physician | Contact Person | Phone and Address |
|  |  |  |
| Dentist Name | Contact Person | Phone and Address |
|  |  |  |
| Psychiatrist Name | Contact Person | Phone and Address |
|  |  |  |
| Therapist Name | Contact Person | Phone and Address |
|  |  |  |
| Pharmacist Name | Contact Person | Phone and Address |
|  |  |  |
| Therapist Name | Date of Birth  | Phone and Address |
|  |  |  |
| Optometrist/Optician Name | Contact Person | Phone and Address |
|  |  |  |
| Specialist Name | Contact Person | Phone and Address |
|  |  |  |
| Social or Case Worker Name | Contact Person | Phone and Address |
|  |  |  |
| Other Health Service Providers Name | Contact Person | Phone and Address |
|  |  |  |

**Medication History**

|  |  |  |
| --- | --- | --- |
| Prescribe Medication | Purpose | Dosage and frequency  |
|  |  |  |
| Prescribe Medication | Purpose | Dosage and frequency  |
|  |  |  |
| Prescribe Medication | Purpose | Dosage and frequency  |
|  |  |  |
| Prescribe Medication | Purpose | Dosage and frequency  |
|  |  |  |
| Prescribe Medication | Purpose | Dosage and frequency  |
|  |  |  |

**Current Agency Assigned Information: For Office Use Only**

|  |  |  |
| --- | --- | --- |
| **Agency**  | **Contact Name**  | **Number**  |
| **NPI Number** | **Therapist** **Direct Supervisor** | **PSR Provider:****BST Provider:****Case Manager:**  |
| Assessment Date | PAR Date :  | Discharge Date:  |
|  | PAR Expire:  |  |

**CONSENT FOR SERVICES**

|  |  |  |
| --- | --- | --- |
| Client’s Name | Client ID# | Referral  |
|  |  |  |

By signing this document, you are indicating that you have been adequately informed as to the benefits and risks of treatment and that you are providing voluntary consent to participate in treatment with ECSN.

**TREATMENT SERVICES PROVIDED**

* Comprehensive Mental Health Assessments are clinical assessments which provide information regarding treatment needs and issues, diagnoses, and make specific recommendations for treatment.
* Therapy is designed to address individual and relationship issues on a deeper level and can be provided to individuals, couples, families, and groups.

**TREATMENT PROVIDERS**

ECSN is comprised of a team of treatment providers with varying professional experience and educational credentials. The particular treatment service and credential of treatment provider is selected based upon the needs of the client.

* Therapists (and Therapist Interns) must be licensed in the State of Nevada as Marriage and Family Therapists, Licensed Clinical Social Workers, or Professional Counselors.
* Clinical Assessors must be Licensed Clinicians (i.e. Marriage and Family Therapist, Licensed Clinical social Worker, Certified Professional Counselor, Psychologist, etc.)

**LOCATION OF TREATMENT**

The other rehabilitative mental health services, including psychosocial rehabilitation services and basic skills training are generally provided in the natural environment of the client, such as the home, school, job setting, community, etc. However, services may also be provided in a traditional office setting as well. Likewise, therapy can be provided in the office or in the home. The location of treatment depends on the needs of the client and family. The home setting allows the clinician to work with the family in their natural environment and promotes more powerful and effective interventions given the close working nature with the client and family. However, potential cons to the home setting are that distractions to the therapy session are more common, and it becomes more challenging to maintain confidentiality and privacy with regard to treatment. Some individuals are more comfortable in the privacy of their home to address treatment issues. However, others may feel more comfortable in a more formal office setting. For treatment to be most effective and comfortable for you, it is important that you discuss your preferences with your clinician. Changes can also be made throughout the treatment process.

**POTENTIAL RISKS**

It is important to remember that progress occurs at different rates for different individuals depending on numerous factors. At the same time, addressing significant, personal issues can be a very painful process, especially in the beginning of treatment, until you are able to make positive changes. For some individuals, symptoms may worsen during the course of assessment or treatment. Be sure to inform your clinician or treatment provider if you are experiencing significant distress or your symptoms such as depression or anxiety worsen, so that various treatment options can be discussed. We also ask that you do not terminate treatment without a final meeting with your treatment provider in order to ensure appropriate closure and to provide you with any necessary referrals.

**YOUR RIGHTS AS A CLIENT**

* You have the right to a have a copy of any Comprehensive Mental Health Assessment completed on your behalf.
* You have the right to be involved in your treatment at all times, which includes identifying treatment goals and objectives and various therapeutic interventions to address specific treatment issues.

* You have a right to be informed regarding your progress throughout the treatment process.
* You have the right to privacy and confidentiality of your records regarding treatment.
* You have the right to choose a different treatment provider at any time and will be provided with referrals if necessary.

**LIMITS OF CONFIDENTIALITY**

Privacy and confidentiality are client rights which are protected by state and federal laws. Therefore, all information disclosed in your treatment sessions will be kept strictly confidential unless you provide written authorization to release information. However, there are certain legal exceptions under which the company is required by law to disclose confidential information to the proper authorities: 1) If there is reasonable suspicion of abuse, neglect or exploitation of a child, elderly or disabled person; 2) When a court order is issued for records; or 3) when the client or another individual is in clear and imminent danger. If you threaten to harm yourself, someone else, or the property of others, your treatment provider is required to contact the proper authorities and to take reasonable steps to warn the potential victim and prevent the threatened harm. In such an instance, only the minimal amount of information necessary will be shared with the appropriate authorities or individuals contacted to ensure your safety and that of others. Additionally, when submitting claims to insurance carriers, information such as presenting symptoms, diagnoses and treatment progress must be included in order to obtain authorization for services.

**CANCELLATION OF APPOINTMENTS**

Appointments are mutually arranged between you and the treatment provider and in order for treatment to be most effective attendance should be regular and consistent. If you are unable to keep your appointment which has been reserved for you, please contact the provider at least 24 hours in advance.

**AFTER HOUR EMERGENCIES**

In the event of emergency after hours, contact 911. Should you leave a message with the agency after business hours that you are in need of immediate attention, we will contact you within the first business day to arrange an emergency appointment.

**CONSENT FOR TREATMENT SERVICES**

I have read the information contained in this Consent for Treatment and have been adequately informed regarding the potential risks and benefits of treatment. I am voluntarily providing consent for treatment with Empowerment Center of Southern Nevada LLC with the regard to the specific services indicated by my initials and signature below:

\_\_\_\_\_ Comprehensive Mental Health Assessment

\_\_\_\_\_ Therapy

**ASSIGNMENT AND RELEASE**

Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Soc. Sec.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy / Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, provide my consent for the above treatment services as indicated by my initials. I further certify that I, or my dependent, has insurance coverage as indicated above and assign directly to my treatment provider all insurance benefits payable for services rendered. Additionally, I authorize ECSN to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

I have been provided with a copy of this document for my records and understand that I may withdraw or modify this Consent for Treatment and Assignment/Release of my insurance benefits (or those of my dependent) at any time by informing ECSN in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Client Signature of Client Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Legal Guardian Signature of Legal Guardian Date**

*Consent must be provided by all custodial parents or legal guardians.*

EMPOWERMENT CENTER OF SOUTHERN NEVADA

Emergency Medical Consent

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the legal guardian of the above named child, provide my consent for the staff Empowerment Center of Southern Nevada to obtain emergency medical treatment for my child if necessary. This consent shall remain in effect for one year unless I revoke it in writing.

Choice of Doctor or Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Mental or Physical Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of emergency, I understand that staff of Empowerment Center of Southern Nevada may need to seek the nearest available treatment rather than the choice of doctor or hospital specified above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Legal Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Legal Guardian**

 **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**