CHOICE-BHM

BEHAVIORAL HEALTH MANAGEMENT

License #: SA0822179

O: 313-965-7880 E: Choicebhm@gmail.com www.choice-bhm.org

Intake Date:

Type of Service: Domestic Violence Anger Management Substance Abuse Parenting Gambling Behavioral Health Management

Probation Officer: ____________________

Client's Name: ____________________

Address: ____________________

Last 4 of Social Security #: __________ Cell: __________ Email: __________

Any medical problems or medications? (i.e., diabetes, high blood pressure, heart problems)

____

History of Alcohol or Drug use (if applicable):

What type of drugs, how long, when did you last use? ____________________

Employment (If applicable): ____________________

Shift/hours worked? ____________________

CONTRACT WITH CLIENT:

I agree to cooperate/participate with the rules and staff of the **C.H.O.I.C.E.** program.

I agree that CHOICE-BHM/MCHT/WSU **ARE NOT** liable for my actions before, during or after attending sessions in-person or virtual.

I agree to pay $25.00 per session and C.H.O.I.C.E. may/may not use my image in any/all media and advertising.

I UNDERSTAND THAT IF I HAVE TWO (2) CONSECUTIVE ABSENCES I WILL BE TERMINATED FROM THE C.H.O.I.C.E. PROGRAM.

Clients Signature: ____________________

Clinical Therapist: Dr. Paul A Turner, Jr. D.D. CADC-M

Dr. Paul A. Turner, Jr. D.D. CADC-M