EMPOWER COUNSELING

Child Intake Form

Today's Date _____ **Name of Primary Client:** _____

Social Security #: _____ Date of Birth: _____ Gender: _____

Address: _____

Who has legal custody of this client? _____
(consent is required from legal custodian and documentation may be required)

Emergency Contact: _____ Phone: _____

Child's Living Arrangement: (with bio parents, split custody, step parents, foster care) _____

Mother's Name: _____ DOB: _____ Date of Death: _____

Mother's Address: _____ May we send mail? ☐ Yes ☐ No

Phone: _____ Ok to leave messages? ☐ Yes ☐ No Email: _____

Mother's Occupation: _____

Father's Name: _____ DOB: _____ Date of Death: _____

Father's Address: _____ May we send mail? ☐ Yes ☐ No

Phone: _____ Ok to leave messages? ☐ Yes ☐ No Email: _____

Father's Occupation: _____

Other Legal Custodian Name: _____

Address: _____ May we send mail? Yes ☐ No ☐

Phone: _____ Ok to leave messages? ☐ Yes ☐ No Email: _____

Information about other people/adults in the child's life (involvement, relationship quality, etc.): _____

_____

_____

What is the reason for seeking counseling services? _____

_____

_____

When did this issue begin? _____ Did anyone refer you? ____ If yes, who? _____

What changes do you and your child would like to see happen as a result of counseling? _____

_____

What strengths does your child possess? _____

_____

Primary Household				
Household Member Name	Relationship To Child	Age	Occupation/School	Quality of Relationship

**** If the child lives in more than one household, please fill the below section out ****

Secondary Household				
Household Member Name	Relationship To Child	Age	Occupation/School	Quality of Relationship

Developmental History & Concerns

Pregnancy:	**Yes**	**No**	**Unknown**
Had bleeding during the pregnancy	☐	☐	☐
Had toxemia	☐	☐	☐
Had to take medication Specify the medication: _____	☐	☐	☐
Got injured or hurt	☐	☐	☐
Gained less than 15 lbs	☐	☐	☐
Took narcotic drugs	☐	☐	☐
Drank alcohol	☐	☐	☐
Had an infection	☐	☐	☐
Smoked during the pregnancy	☐	☐	☐
Other pregnancy problems/illnesses Please specify _____	☐	☐	☐
Length of the pregnancy: _____	☐	☐	☐

BIRTH	Yes	No	Unknown
Born prematurely	☐	☐	☐
Born with the cord wrapped around neck	☐	☐	☐
Injured during birth	☐	☐	☐
Had trouble breathing	☐	☐	☐
Turned blue (cyanosis)	☐	☐	☐
Had an infection	☐	☐	☐
Had seizures	☐	☐	☐
Needed oxygen	☐	☐	☐
Was jittery	☐	☐	☐
Other birth complications Specify: _____	☐	☐	☐

CHILDHOOD HEALTH ISSUES	Yes	No	Unknown	If yes, what age did it start?	If yes, still occurring?
Seizures	☐	☐	☐		☐
High fevers (over 103 F)	☐	☐	☐		☐
Head Injury	☐	☐	☐		☐
Asthma	☐	☐	☐		☐
Hearing Difficulties	☐	☐	☐		☐
Vision Difficulties	☐	☐	☐		☐
Other Serious illness	☐	☐	☐		☐
Other Hospitalizations	☐	☐	☐		☐

FUNCTIONING	Yes	No	Unknown	If yes, what age did it start?	If yes, still occurring?
Poor Appetite	☐	☐	☐		☐
Constipation	☐	☐	☐		☐
Stomachache	☐	☐	☐		☐
Trouble Falling Asleep	☐	☐	☐		☐
Trouble Staying Asleep	☐	☐	☐		☐
Overly active	☐	☐	☐		☐
Head banging	☐	☐	☐		☐
Rocking in bed	☐	☐	☐		☐
Temper tantrums	☐	☐	☐		☐
Crying often/easily	☐	☐	☐		☐
Shyness with strangers	☐	☐	☐		☐
Irritability	☐	☐	☐		☐
Extreme reaction to noise or sudden movements	☐	☐	☐		☐
Self-destructive behavior	☐	☐	☐		☐
Difficulty being comforted/consoled	☐	☐	☐		☐

BEHAVIORS	Yes	No	Unknown	If yes, what age did it start?	If yes, still occurring?
Has Bad Dreams	☐	☐	☐		☐
Is Quiet or Withdrawn	☐	☐	☐		☐
Is often down or hard on him/herself	☐	☐	☐		☐
Is tired often	☐	☐	☐		☐
Wets bed or pants often	☐	☐	☐		☐
Soils underwear with bowel movements	☐	☐	☐		☐
Is often too neat or orderly	☐	☐	☐		☐
Too concerned with cleanliness	☐	☐	☐		☐
Plays with matches	☐	☐	☐		☐
Destroys objects	☐	☐	☐		☐
Is cruel to animals	☐	☐	☐		☐
Is not liked by other children	☐	☐	☐		☐
Feels ill on school mornings	☐	☐	☐		☐
Has eating problems (over/under eats)	☐	☐	☐		☐
Part of a clique/gang that causes trouble	☐	☐	☐		☐
Concerns with sexual development/behaviors?	☐	☐	☐		☐

Comments: _____

_____

_____

ATTENTION ISSUES	Yes	No	Unknown	If yes, what age did it start?	If yes, still occurring?
Can only concentrate for a short time unless things are very interesting	☐	☐	☐		☐
Understands main concepts but misses important details	☐	☐	☐		☐
Completes tasks carelessly/ without thinking	☐	☐	☐		☐
Learns a new skill one day and then can't seem to do it a few days later	☐	☐	☐		☐
Receives unpredictable grades or test scores in school	☐	☐	☐		☐
Often doesn't notice when he/she makes a mistake	☐	☐	☐		☐
Seems not to realize when he/she is disturbing someone	☐	☐	☐		☐
Annoys or bothers other children	☐	☐	☐		☐
Behavior is hard to predict	☐	☐	☐		☐
Seems to want things right away and/or is hard to satisfy	☐	☐	☐		☐
Bullies others	☐	☐	☐		☐
Doesn't do much better after punishment or correction	☐	☐	☐		☐

School Functioning

Does your child receive special education services (Ex- IEP or 504)? ☐ Yes ☐ No

If Yes, what services/accommodations do they qualify for?_____

_____

Child's Substance History

Do you have concerns about your child's use of alcohol or drugs? ☐ Yes ☐ No

QUESTIONS FOR THE CHILD TO ANSWER DO YOU USE:	CURRENT	PAST	NEVER	COMMENTS- how often?
Caffeine	☐	☐	☐	
Tobacco products (including vaping)	☐	☐	☐	
Alcohol	☐	☐	☐	
Illegal Drugs (including marijuana)	☐	☐	☐	
Medication beyond prescribed usage	☐	☐	☐	

	Yes	No
Have you ever felt that you out to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs first think in the morning (eye opener) to steady your nerves: ex- to get rid of hangover, or get the day started?	☐	☐

Child's Legal History

Does your child have a history of legal charges? ☐ Yes ☐ No
If yes, describe the charges: _____

_____

Child Psychiatric/Therapy History

Please list any psychiatry and or therapy provider that has worked with your child.				
Provider	**Agency**	**Dates**	**Reason?**	**Still working with them?**

Primary Care Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip:_____

Please list any medication your child is currently on, dosage, frequency, and who prescribed: _____

_____

_____

_____

Other Family Concerns							
	No	Yes	Primary Client	Mother	Father	Sibling	Other
Health Problems	☐	☐	☐	☐	☐	☐	☐
Disability	☐	☐	☐	☐	☐	☐	☐
Legal Issues	☐	☐	☐	☐	☐	☐	☐
Financial Concerns	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Mania	☐	☐	☐	☐	☐	☐	☐
Schizophrenia/Psychosis	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Eating Problems	☐	☐	☐	☐	☐	☐	☐
Trouble with the Law	☐	☐	☐	☐	☐	☐	☐
Physically Abusive	☐	☐	☐	☐	☐	☐	☐
Physically Abused	☐	☐	☐	☐	☐	☐	☐
Sexually Abusive	☐	☐	☐	☐	☐	☐	☐
Sexually Abused	☐	☐	☐	☐	☐	☐	☐
Verbally Abusive	☐	☐	☐	☐	☐	☐	☐
Verbally Abused	☐	☐	☐	☐	☐	☐	☐
Emotionally Abusive	☐	☐	☐	☐	☐	☐	☐
Emotionally Abused	☐	☐	☐	☐	☐	☐	☐
Significant Family Stressors (moves, deaths, divorce, loss of employment)	☐	☐	☐	☐	☐	☐	☐
Comments (Specify problems that impact child's needs):							

Child's Trauma History

Has Child Protective Services (CPS) been involved with the family? ☐ Yes ☐ No

If yes, please describe: _____

Has your child been placed outside of the home? ☐ Yes ☐ No
If yes, where and for how long? _____

Name of CPS Worker and/or Case Manager assigned to the family (if applicable): _____

Name of the Guardian ad Litem (GAL) assigned to the family: _____

Other Information

Any other information you feel is important for the counselor to know? _____

_____

_____

Consent to receive electronic appointment reminders:

Empower Counseling is able to send appointment reminders to your email address or via text.

An email or text would arrive and would include the clients name, date, and time of the appointment, as well as the name of the provider you will be seeing.

I authorize Empower Counseling to send appointment reminders as following *(choose ONLY one)*:

☐ To the following email address: _____ Initial and Date: _____

OR

☐ Via text message to the phone number _____ Initial and Date: _____

Please let us know if any of this information changes to ensure message delivery

Empower Counseling Fee Agreement

The cost for Counseling Services at Empower Counseling is:

- $350 for an Initial Diagnostic Assessment
- $300 for a 53-60 min Individual Therapy Session
- $250 for a 38-52 min Individual Therapy Session
- $200 for a 18-37 min Individual Therapy Session
- $300 for Family Therapy (with and without client)
- $30 for Interactive Complexity
- $250 for Consultation with Family
- $150 for Preparation of Reports
- $10 for Emotional/Behavioral Assessment
- $200 for Behavioral Assessment (with ND MA)
- $42.50 for Individual/Group Counseling (per 15 min with ND MA)
- $50 for Intensive-In-Home (per 15 min with ND MA)

For individuals who have a diagnosable mental health condition we will bill your insurance company, in which case we will need an insurance information form completed and a copy of your insurance card. You are responsible to pay for the portion that your insurance company does not pay (co-pay, deductible, etc.).

You may also choose to utilize your Employee Assistance Program. Lastly, if you would prefer self-pay for our services you would need to speak with Empower Counseling to discuss fees and a payment plan.

My fee agreement is: (check all that apply) Client Name: _____

☐ Bill EAP only

☐ Bill Client only; self-pay amount is $_____Initial and $_____Ongoing

☐ Bill Insurance:

Insurance Plan: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Number _____ Group Number _____

Co-pay to be paid by client at time of session: $_____

Deductible amount: $_____

I understand that by signing this fee agreement I am making the commitment to pay for my sessions in the manner agreed upon. I also agree that it is my responsibility to inform my counselor if my financial situation changes and I need to initiate a new fee agreement. I also understand that I may be charged for any missed appointment not cancelled at least 24 hours in advance.

_____ _____

Client/Parent/Guardian Signature Date

_____ _____

Clinician Signature Date

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

1. Empower Counseling is permitted to make uses and disclosures of Protected Health Information for treatment, payment and health care operation, as described in the following examples:
    a. For payment: Protected Health Information about you may be disclosed to your insurance company for purposes of service billing and payment. Disclosures may also be made to a county social service department if your services were arranged by and are being paid for by that department.
    b. For health care operations: Protected Health Information about you may be reviewed as an audit by your insurance company.
2. Empower Counseling is permitted or required, under specific circumstances, to use or disclose Protected Health Information without the individual's written authorization.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization at any time.
4. Any request to share Protected Health Information of services involving more than one individual, such as in family or couples' therapy, all individuals of consenting age must submit a written authorization before records can be disclosed.
5. Empower Counseling will contact the individual to provide appointment reminders or other benefits/services that may be of interest to the individual.
6. The Individual has the following rights regarding Protected Health Information:
    a. The right to request restrictions on certain uses and disclosures of Protected Health Information. Empower Counseling is not required to agree to a requested restriction.
    b. The right to receive confidential communication of Protected Health Information, as applicable.
    c. The right to inspect and copy Protected Health Information, as provided in the Privacy Regulation.
    d. The right to amend Protected Health Information, as provided in the Privacy Regulation.
    e. The right to receive an accounting of disclosures of Protected Health Information.
    f. The right to obtain a paper copy of the Notice from the covered entity upon request.
7. Empower Counseling is required by law to maintain the privacy of Protected Health Information and to provide individuals with notice of its legal duties and privacy practice with respect to Protected Health Information.
8. Empower Counseling is required to abide by the terms of the notice currently in effect.
9. Empower Counseling reserves the right to change the terms of the Notice. The current notice will be posted at Empower Counseling and include the effective date.
10. Empower Counseling will provide individuals with a revised Notice by distribution at the time of services is first provided following the revision.
11. Individuals may complain to Empower Counseling and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the LLC, if they believe their privacy rights have been

violated. To file a complaint with Empower Counseling, the individual must contact Mandy Bernardy at 532-1477 or with the Secretary of Health and Human Services in writing.

12. This Notice is first in effect 04/10/2019.
13. Empower Counseling elects to limit the uses or disclosures that it is permitted to make, as follows:
    a. Empower Counseling will only make routine disclosures to family members of Protected Health Information with a valid authorization from the individual.
    b. Disclosures for specialized government activities and worker's compensation programs will only be made with a valid authorization from the individual.

I hereby acknowledge that I have received a copy of Empower Counseling Notice of Privacy Practices.

Client Printed Name: _____

Client Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Clinician Name:_____

Clinician Signature: _____ **Date:** _____

Client Rights, Responsibilities, & Informed Consent

Empower Counseling believes in client rights to confidentiality and self-determination. With the exception to specific circumstances described below, you have the right to confidentiality and the freedom of choice regarding services received.

Client Rights: Each individual has rights related to services received, including:

1) The right to self-determination and to be treated with respect in a culturally appropriate manner.
2) The right to be free from any discrimination, abuse, or exploitation at Empower Counseling.
3) That Empower Counseling will accommodate services to best meet individual needs.
4) The right to access your file according Empower Counseling policy.
5) The right to be made aware of services available and to terminate at any time.
6) The right to ask any questions about anything that happens in therapy and be informed of any risks and benefits associated with therapy.
7) The right to understand your therapist's qualifications, training, and areas of expertise.
8) The right to confidentiality by policy and law through verbal, written, or electronic communication. It is important that you are aware that under the following circumstance, Empower Counseling is required by law to release client information and a report may be filed to the appropriate authorities:
    a. It is determined that you are a danger to yourself or others.
    b. There is concerns of child abuse or neglect.
    c. There are concerns of abuse or neglect of a vulnerable adult
    d. We are subpoenaed by court to testify or submit records to court.

Agency Expectations: Empower Counseling has the right to deny services based on the following circumstances:

1) That clients will arrive on time for sessions and cancel sessions within 24-hour notice. **Empower Counseling Policy regarding late show/no show session is that clients that late show (cancel sessions in less than 24-hour notice) or no-show appointments for TWO or more consecutive sessions will not be able to schedule further sessions unless approved by your therapist.**
2) That clients will not be under the influence of any substances during sessions.
3) That clients will not be physically, verbally, or emotionally abusive towards their therapist.
4) That clients will maintain confidentiality of other clients and/or client information.
5) That clients are responsible for payment of all services received that are not covered by an insurance or other payment plan.

By signing below, I am stating that I have reviewed this statement, and understand the above information:

Client Printed Name: _____ **Date:**_____

Client Signature: _____

Parent/Guardian Signature: _____ **Date:**_____

Clinician Name: _____

Clinician Signature: _____ **Date:**_____

Empower Counseling No Show/Late Cancel Policy

Empower Counseling understand that life happens and we know the reason you are here is to prioritize your mental health. In order for our patients to be successful and to streamline our scheduling process, the following policy will be effective 8/1/2023.

DEFINITIONS:

LATE CANCEL - Less than 24-hour notice.

NO SHOW -— A missed appointment is not showing up, failure to reschedule within Empower Counseling guidelines and arriving late.

1. Appointment reminders will be sent via text and email approximately 48 hours prior to the scheduled appointment. These reminders are a courtesy.
   a. If you are not receiving appointment reminder messages, please contact our office to make sure we have your correct information on file.
   b. Failure to keep your appointment will result in a late fee. You are responsible for keeping your scheduled appointments regardless of whether a reminder was sent or received.
   c. If you are more than 15 minutes late for your appointment, it is considered a no show and you will be charged a fee.

2. If you cannot attend the scheduled session, please reach out and let Empower Counseling staff know so we can find an alternative time that works for you and the clinician.

   a. When you schedule an appointment and do not show up or cancel, we are unable to reschedule someone else who needs our services.
   b. Our job at Empower Counseling is to ensure the community's mental health is being served to the best of our ability. We hope you respect our time, as we respect yours,

3. You will be given 1 “free pass” for no show/late cancel each calendar year.
4. **BILLABLE CHARGES:**
   a. No Show rate ¡is $50.00.
   b. Late Cancel rate is $25.00,
   c. These charges are the responsibility of the patient.
5. After 3 consecutive no-shows/late cancels no appointments will be scheduled until you have contacted your therapist directly regarding scheduling.
   a. Your therapist will be able to help eliminate any barriers you may be encountering.
   b. Empower Counseling can provide service options to help mitigate obstacles.
   c. Maybe you just have a lot going on and need to take a break. And that is ok!

Empower Counseling staff care about you and know that life can be chaotic. We want to support your mental health. Late Cancels/No Shows are not a direct reflection of who YOU are, but of your life circumstances. Please communicate with staff,

_____

Client's Name

_____ _____

Client/Client's guardian signature Therapist signature

Telehealth Consent

WHAT IS TELEHEALTH?

"Telehealth" means that sessions will be conducted when the provider and the client are in different physical locations, and that services will be delivered over electronic means. The electronic means are often internet-based technology tools, including videoconferencing software and email.

WHAT WILL I NEED? You will need access to internet service and the technology tools needed in order to engage in telehealth sessions. A computer is best, but a cell phone or tablet would also work. You will need access to your email on that device, and you will also need to have a camera and a microphone so I can both see and hear you. It is best to use a secure wireless connection, as a public or non-secure connection could compromise your confidentiality. I will be using a secure wireless internet connection. It is also best to ensure you are in a private setting where no one can overhear your session, and to minimize distractions to the extent possible.

HOW WILL IT WORK? The platform that I will be using during this time is Google Meet. This is a HIPAA secure platform that is fairly easy to use. I will send you an invitation via your email address at the time of your session, and you can join the meeting through the link provided in your email. **Please let me know via email at mandy@empowercounselingfm.com if you will be unable to attend your session.** If technology fails, I will make an attempt to re-establish a connection. If I am unable to do this, I will call you via phone. **Please provide the phone number you would like me to call if necessary:** _____.

WHAT ARE THE RISKS/BENEFITS? We are fortunate to have telehealth as an option during the COVID-19 Pandemic. It will allow us to continue to meet on a regular basis with minimal disruption to your treatment, while also practicing safe social distancing. Along with the benefits of telehealth come some risks, and it is important for you to know these before you consent to telehealth treatment. Technology can fail and occasionally it could be difficult to re-establish a connection, which can be disruptive to a session. It is harder to ensure the confidentiality of your session when using telehealth than it is in person. Technology is vulnerable to electronic breaches of information. As stated above, both provider and client need to take appropriate measures to prevent this from occurring.

OTHER THINGS TO KNOW

- You can choose to cease telehealth sessions at any time, and resume face to face counseling when it is determined safe to do so.
- You can revoke this consent at any time.
- Both provider and therapist are agreeing that we will not record any portion of telehealth sessions.
- Records will be kept in the same manner as they are for in-person sessions.
- If you are using health insurance or an employee assistance program to cover costs, you will want to contact your plan to ensure that telehealth is covered. Many have made changes to their policies during the COVID-19 Pandemic, but you will want to check on the specifics of your plan.

I have read this document and agree to proceed with telehealth sessions.

Name	Date	Signature
Name	Date	Signature

EMPOWER COUNSELING

YOUTH OUTCOME QUESTIONNAIRE (Y-0Q®-30.2)

Purpose: The Y-008-30.2 is designed to describe a wide range of situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation, If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-003-30.2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that, [f you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

Directions: Read each statement carefully, Check the box that most accurately describes the past week. Decide how true this statement is during the past **7 days.** Check only one answer for each statement and erase unwanted marks clearly.

Directions for parents/guardians completing questionnaire: If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire, in this case, respond to the statements as if each began with "My child..." or "My child's...* rather than "L..* or My...." It is important that you answer as accurately as possible based on your personal observation and knowledge.

PERSON COMPLETING FORM (PLEASE CHECK):

☐ Adolescent ☐ Parent/guardian ☐ Other

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.....	☐ 0	☐1	☐2	☐3	☐4
2. I don't participate in activities that used to be fun ..	☐ 0	☐1	☐2	☐3	☐4
3. I argue or speak rudely to others.....	☐ 0	☐1	☐2	☐3	☐4
4. I have a hard time finishing my assignments or I do them carelessly	☐ 0	☐1	☐2	☐3	☐4
5. My emotions are strong and change quickly.....	☐ 0	☐1	☐2	☐3	☐4
6. I have physical fights (hitting, Kicking, biting, or scratching) with my family or others my age.....	☐ 0	☐1	☐2	☐3	☐4
7. I worry and can't get thoughts out of my mind	☐ 0	☐1	☐2	☐3	☐4
8. I steal or lie.....	☐ 0	☐1	☐2	☐3	☐4
9. I have a hard time sitting stilt (or I have too much energy)	☐ 0	☐1	☐2	☐3	☐4
10. I use alcohol or dugs.....	☐ 0	☐1	☐2	☐3	☐4
11. lam tense and easily startled (Jumpy).....	☐ 0	☐1	☐2	☐3	☐4
12. I am sad or unhappy.....	☐ 0	☐1	☐2	☐3	☐4
13. I have a hard time trusting friends, family members, or other adults	☐ 0	☐1	☐2	☐3	☐4
14. I think that others are trying to hurt me even when they are not	☐ 0	☐1	☐2	☐3	☐4
15. I have threatened to, or have run away from home.	☐ 0	☐1	☐2	☐3	☐4
16. I physically fight with adults.....	☐ 0	☐1	☐2	☐3	☐4
17. My stomach hurts or I feel sick more than others my same age	☐ 0	☐1	☐2	☐3	☐4
18. I don't have friends or I don't keep friends very long.	☐ 0	☐1	☐2	☐3	☐4
19. I think about suicide or feel I would be better off dead	☐ 0	☐1	☐2	☐3	☐4
20. I have nightmares, trouble getting to sleep, oversleeping, or waking up t00 early...	☐ 0	☐1	☐2	☐3	☐4
21. I complain about or question rules, expectations, or responsibilities	☐ 0	☐1	☐2	☐3	☐4
22. I break rules, laws, or don't meet others' expectations on purpose	☐ 0	☐1	☐2	☐3	☐4
23. I feel irritated.....	☐ 0	☐1	☐2	☐3	☐4
24. I get angry enough to threaten others.....	☐ 0	☐1	☐2	☐3	☐4
25. I get into trouble when I'm bored	☐ 0	☐1	☐2	☐3	☐4
26. I destroy property on purpose.....	☐ 0	☐1	☐2	☐3	☐4
27. I have a hard time concentrating, thinking clearly, or sticking to task	☐ 0	☐1	☐2	☐3	☐4
28. I withdraw from my family and friends.....	☐ 0	☐1	☐2	☐3	☐4
29. I act without thinking and don't worry about what will happen	☐ 0	☐1	☐2	☐3	☐4
30. I feel like I don't have any friends or that no one likes me.	☐ 0	☐1	☐2	☐3	☐4

ID#: _____Session# _____Date: _____

Client's Name: First _____Last:_____

Informant's Name, (If other Than Client:)_____

DO NOT WRITE IN THIS BOX

∑ =

Authorization to Disclose Protected Health Information

Name of Client: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

CLIENT RELEASE AND SIGNATURE

1- I Hereby Authorize:

_____ at

Empower Counseling
2311 45th St S Suite 4A
Fargo ND 53104
P: 701-532-1477
F: 701-532-1801

2- Permission To: ☐ Disclose To ☐ Obtain From ☐ Mutually Exchange With

Person/Agency: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

3- Description of the Information to be disclosed/obtained:

☐ Family and Social History ☐ Psychological Info/Testing ☐ Legal
☐ Treatment Plan ☐ Progress in Treatment ☐ verbal Consultation as necessary
☐ Discharge Summary ☐ alcohol/Drug Abuse Issues/Treatment ☐ coordination of Care
☐ Other (Provide details): _____

4- This information identified above will be used for:

☐ Coordination of Care/Treatment/Discharge Planning ☐ Legal ☐ At the Request of the Individual
☐ Billing/Payment ☐ collateral ☐ Eligibility Determination
☐ Other (must specify to be valid): _____

5- Authorization remains in effect for one year from date signed unless a different date is entered here: _____

CLIENT CONSENT: This authorization is voluntary and remains in effect until the expiration unless specifically evoked, I understand that I may revoke my consent to allow Empower Counseling to release/obtain information, at any time, except to the extent that action will have been taken on information released prior to the revocation of my consent. I understand that my records are protected under State and Federal confidentiality regulations.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota few, the signature of a minor. 12 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required To authorize the disclosure of substance use disorder information.

☐ **CHECK IF APPLICABLE — NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS**

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Witness (if needed): _____ Date: _____