Email: refocus123@gmail.com

Client Intake Information:

Date of Referral: _____

Person of Referral: _____

Insurance Company:_____

Insurance ID:_____

Contact Number:_____

Policy Number:_____

Service(s) Requested (please check all that apply):

☐ Substance Abuse Counseling	☐ Family Counseling
☐ Substance Abuse Assessment	☐ Domestic Violence Assessment
☐ Group Counseling	☐ Marriage and Family
☐ Individual Counseling	☐ Private Insurance
☐ Trauma Assessment	☐ Other:_____

Client Basic Information:

Client Name:_____

Gender:_____

Race/Ethnicity _____

Religion/Spirituality:_____

Education:_____

Hobbies, skills, or interests:_____

_____

Social Security Number:_____

Date of Birth:_____

Phone Number:_____

Email Address:_____

Residential Address:_____

City:_____ State:_____ Zip Code:_____

Employer and Status Information:

Company:_____

Job Title:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Please check if applicable:

☐ I am self-employed ☐ I am unemployed

☐ I am retired ☐ Other:_____

I am:

☐ Single ☐ Divorce

☐ Married ☐ Other:_____

How many people live in your household?_____
Do you have any children?_____
If yes please list name(s) and age(s):_____
_____

Emergency Contact Information:

Name:_____
Relationship to Client:_____
Phone Number:_____

Health and Medical Information:

Primary Care Physician:_____
Phone Number:_____
Psychiatrist:_____
Phone Number:_____
Please list any medical problems_____
_____
_____
_____
Please list any current medication_____
_____
_____

Personal and Family History:

Have you or a close relative ever been hospitalized for a psychiatric illness?_____
Does anyone in your family have a mental illness?_____
Has anyone in your family ever attempted or committed suicide?_____
Does anyone in your family have a substance abuse problem?_____
Have you ever been arrested?_____
If yes to any of the above, please briefly explain._____
_____
_____
_____
_____
_____
Other personal or family information:_____

_____
_____
_____

Additional Information:

Are you required by a court of law to receive counseling as part of legal proceeding?
_____

Have you obtained services from Refocus before?_____
If yes, when?_____
Are you currently affiliated with other treatment programs?_____
On what number may we leave a confidential message?_____
How did you hear about Refocus?_____-_
_____

Have you ever attended an AA, NA, SA, ALANON, or any other addiction treatment service?_____
If yes, when?_____
When did the health condition that you are seeking treatment for begin?_____
_____

Client Intake Basic Questions:

Please check one response. Each question is based on a scale of 1 to 10; 1 being poor, 5 being moderate, and 10 being excellent.

1. How well are you doing at your job?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
2. How well are you doing in your marital/ significant other relationship?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
3. How well are you doing in your family relationship?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
4. How well are you doing in relationships outside of your family?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
5. How is your current physical health?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
6. How is your current mental health?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
7. What is your general level of happiness and well-being?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptom Assessment

Please give as accurate and honest of account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor. Check all symptoms below.

I am experiencing:

Frequent worry or tension	☐Never	☐Seldom	☐Often	☐Always
Fear of many things	☐Never	☐Seldom	☐Often	☐Always
Discomfort in social situations	☐Never	☐Seldom	☐Often	☐Always
Feelings of guilt	☐Never	☐Seldom	☐Often	☐Always
Phobias: unusual fears	☐Never	☐Seldom	☐Often	☐Always
Panic attacks	☐Never	☐Seldom	☐Often	☐Always
Recurring, distressing thoughts	☐Never	☐Seldom	☐Often	☐Always
Flashbacks of a traumatic event	☐Never	☐Seldom	☐Often	☐Always
Avoidance of people or places	☐Never	☐Seldom	☐Often	☐Always
Nightmares about a traumatic experience	☐Never	☐Seldom	☐Often	☐Always

I am feeling:

Decreased interest in pleasurable activities	☐Never	☐Seldom	☐Often	☐Always
Social isolation or loneliness	☐Never	☐Seldom	☐Often	☐Always
Suicidal thoughts	☐Never	☐Seldom	☐Often	☐Always
Bereavement or feelings of loss	☐Never	☐Seldom	☐Often	☐Always
Changes in sleep: too much or too little	☐Never	☐Seldom	☐Often	☐Always
Normal daily tasks require more effort	☐Never	☐Seldom	☐Often	☐Always
Sad and hopeless about the future	☐Never	☐Seldom	☐Often	☐Always
Low self-esteem	☐Never	☐Seldom	☐Often	☐Always

I notice:

I am angry, irritable, or hostile	☐Never	☐Seldom	☐Often	☐Always
I feel euphoric or highly optimistic	☐Never	☐Seldom	☐Often	☐Always
I have racing thoughts	☐Never	☐Seldom	☐Often	☐Always
I need less sleep than usual	☐Never	☐Seldom	☐Often	☐Always
I am more talkative	☐Never	☐Seldom	☐Often	☐Always
My mood fluctuates: goes up and down	☐Never	☐Seldom	☐Often	☐Always

I have:

Risk taking behaviors	☐Never	☐Seldom	☐Often	☐Always
Compulsive or obsessive behaviors	☐Never	☐Seldom	☐Often	☐Always

Acted without concern for consequences	☐Never	☐Seldom	☐Often	☐Always
Been physically harming myself	☐Never	☐Seldom	☐Often	☐Always
Been violent toward others	☐Never	☐Seldom	☐Often	☐Always

I use:

Alcohol	☐Never	☐Seldom	☐Often	☐Always
Nicotine	☐Never	☐Seldom	☐Often	☐Always
Marijuana	☐Never	☐Seldom	☐Often	☐Always
Cocaine	☐Never	☐Seldom	☐Often	☐Always
Opiates	☐Never	☐Seldom	☐Often	☐Always
Sedatives	☐Never	☐Seldom	☐Often	☐Always
Hallucinogens	☐Never	☐Seldom	☐Often	☐Always
Stimulants	☐Never	☐Seldom	☐Often	☐Always
Methamphetamines	☐Never	☐Seldom	☐Often	☐Always
Caffeine	☐Never	☐Seldom	☐Often	☐Always

My eating involves:

Restriction of food consumption	☐Never	☐Seldom	☐Often	☐Always
Binging and purging	☐Never	☐Seldom	☐Often	☐Always
Binging	☐Never	☐Seldom	☐Often	☐Always
A lot of weight loss or gain	☐Never	☐Seldom	☐Often	☐Always

I have:

Concern about my sexual function	☐Never	☐Seldom	☐Often	☐Always
Discomfort engaging in sexual activity	☐Never	☐Seldom	☐Often	☐Always
Questions about my sexual orientation	☐Never	☐Seldom	☐Often	☐Always

Employment and self-care:

I have problems getting or keeping a job	☐Never	☐Seldom	☐Often	☐Always
I have problems paying for basic expenses	☐Never	☐Seldom	☐Often	☐Always
I am afraid of becoming homeless	☐Never	☐Seldom	☐Often	☐Always
I have problems accessing healthcare	☐Never	☐Seldom	☐Often	☐Always

Any other symptoms or behaviors of concern to be noted:_____

_____

_____

_____

_____

_____

Consent for Treatment

Thank you so much for choosing the services provided at Refocus. This document is designed to inform you about what you can expect from our staff regarding confidentiality, emergencies, and details regarding the process of treatment. Therapy at Refocus ensures a cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience. Please be sure to read the following carefully.

Fees and Appointments:

- Appointments are approximately 1 hour in length and take place on a weekly basis. Your counselor holds your specific hour for you each week. If you are unable to keep an appointment, please cancel as soon as possible. Failure to provide a 24-hour cancelation notice will result in being charged the normal hourly appointment rate. If you are able to reschedule your appointment within five working days, it will not count as a cancellation. We ask that you pay the receptionist prior to your session each week. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
- During your initial appointment you will be assigned a fee for your weekly sessions based on your ability to pay. Please discuss any concerns regarding your financial status with your counselor, especially if your financial situation should change or improve. Additionally, once per year your fee will be reevaluated. If it is determined that, based on your circumstances, you are able to pay more, your fee may be adjusted. All client fees are reviewed on an annual Basis.
- There is a service fee for any returned checks. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.

Cost of Treatment

- The fee for the standard hour appointment is $125.00 for individual, couple, or family therapy sessions. Rates may vary depending on the different needs of each client and decision is to be assessed by the councilor. The staff of Refocus has the right to evaluate fees as necessary. The fee for group therapy sessions is $45.00 for a 60-minute session. The initial assessment appointment is billed at a range of $150.00-$250.00 depending on the purpose of the examination. The cash payment discount for clients is $100.00 for individual therapy sessions and $40.00 for group therapy sessions.

Insurance, Co-payments, Deductibles:

- Be aware that an agent of your insurance company or other third-party payer may be given information about the type, cost, and dates of service you receive. Be aware that Refocus will verify your insurance at the time of your appointment. Active insurance is required at the time of all appointments or you will pay for your session out of pocket. At the time of your appointment, you will be required to make any co-payment or payment towards your deductible as outlined by your insurance policy. We can provide you with documentation of your required payments as well as a super bill towards meeting your deductible. Payment is accepted in the form of cash, checks, credit, or debit.

Confidentially:

- Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on "Training and Supervision").
- Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
    - If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
    - If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
    - If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct
    - If you introduce your emotional condition into a legal proceeding.
    - If there is a court order for release of your records.

Training and Clinical Supervision:

- Refocus is a treatment center for counseling and psychology interns and Senior Peer paraprofessional counselors. All counselors at Refocus are under the supervision of licensed mental health professionals. Counselors have successfully met the requirements and are certified addiction counselors.

Hours of Operation:

- Refocus hours of business is 9:00 am to 5:00 pm Monday through Friday. If for any reason you cannot get in contact with a staff member, we guarantee to return communication within the next business day.

Counselor Availability and After-Hours Emergencies:

- Counselors check for voice mail messages during normal business hours. Messages left outside of normal hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department or call 911.

Child Care Release:

- Refocus does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

Drug and Alcohol Screens:

- In the course of some treatment conditions a drug or alcohol screen may be warranted. I understand that if screens are requested, failure to participate is considered a positive screen. Refocus uses Precision-Plus multi panel test cup for urine samples. It is to be noted that drug and alcohol screens are only for treatment coordination and care; positive results will not be reported to legal authorities outside of any mandated reporting.

Social Media and Web Networking:

- Refocus employees and counselors will not accept friend or connection requests from any current or former clients on any social media platform such as Facebook, Twitter, Instagram, Pinterest, LinkedIn, etc. Due to the fact that networking may compromise your confidentially and misconstrued the boundaries of the client and counselor relationship. Please refrain from using any social media as a means of communication with any staff member from Refocus. To uphold confidentiality, we will not search for any client on Google, Bing, or any other search engine or social media systems.

Consent for Treatment and Client Contract:
Please initial below all of the following statements.

_____I understand all of the information provided above. I do hereby seek and consent to receive treatment from Refocus. I understand that developing a treatment plan and regularly reviewing my progress toward meeting specific treatment goals, and regular participation in appointments is expected. I agree to play an active role in this process

_____I understand that no promises have been made to me as to the result of my treatment or any procedure provided by Refocus.

_____I am aware that I may stop treatment at any time unless treatment is required by medical or legal authority. The only I will still be responsible for is any outstanding financial responsibilities. I understand that I may lose services or have to deal with other problems if I stop treatment.

_____I am aware that any agent from my insurance company or third-party payer may be given information regarding my treatment.

_____I understand that I have been given the opportunity to have all questions and concerns fully answered or addressed.

_____I understand that if I have any questions regarding the consent for treatment I can contact Refocus.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to Refocus to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

_____

Printed Name of Client Date

_____

Signature of Client Date

_____

Printed Name of Parent/Guardian (if applicable) Date

Signature of Parent/Guardian (if applicable) Date

HIPPA Consent to Use and Disclose Your Health Information

This form is an agreement between you, the client, and your therapist. As a client of Refocus, you are guaranteed to specific protections in accordance with the United States Health Insurance Portability and Accountability Act.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

Please read and sign this Consent form. If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you. In the future we may change how we use and share your information; this may change our Notice of Privacy Practices. If we do change it, you may obtain a copy by calling us at (912) 243-9310 .If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Printed Name of Client Date

Signature of Client Date

Printed Name of Parent/Guardian (if applicable) Date

Signature of Parent/Guardian (if applicable) Date

Authorization to Use and Disclose Protected Health Information

This release is for the purpose of case planning, evaluation and treatment or counseling

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I authorize to use or disclose to and from Refocus or its duly authorized representatives, all of the following information:

☐ Social	☐ Family	☐ Criminal
☐ Financial	☐ Psychological	☐ Psychiatric
☐ Presentence Investigation	☐ Employment	☐ Educational/School
☐ Supervision Conditions	☐ Workers Comp	☐ Probation/Parole/Criminal
☐ Child Welfare		

☐Other_____

I understand and agree that this authorization will be valid and in effect from _____and expires _____ of the end of supervision/treatment. I understand that after that date or event, no more of this information can be used or disclosed to the person or organization unless I sign a new Authorization like this one. I understand that I can revoke or cancel this authorization at any time by giving written notice delivered by certified mail to all parties including Refocus. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this form. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may redisclose and no longer protected by those regulations.

_____

Printed Name of Client Date

_____

Signature of Client Date

_____

Printed Name of Parent/Guardian (if applicable) Date

_____

Signature of Parent/Guardian (if applicable) Date

Client Rights and Responsibilities

Every client at Refocus has human, civil, and personal rights to be respected and honored at all times. In addition, it is the responsibility of all clients to act in a manner that respects the rights of others. Refocus is committed to the protection of all individual rights and to providing services within an environment that is known by dignity and respect for all persons. Furthermore, Refocus is responsive to the unique needs, abilities, and characteristics of each person served by the organization.

You have the right:

- To service without discrimination on account of race, religion, sex, ethnicity, age, sexual orientation, disability, or cultural background.
- To exercise all fundamental human, civil, constitutional, and statutory rights to which you are entitled as a legally competent citizen unless such rights are limited under due process of law.
- To be treated in a manner that respects your individual dignity and protects your health and safety at all times.
- Be fully informed about the course if your care and decisions that may affect your treatment.
- Revoke your consent for treatment at any time.
- Timely and accurate information to assist you in making decisions regarding your treatment.
- Be fully involved as an active participant in decisions regarding your treatment.
- Have an individual identified in writing that will direct and coordinate your treatment.
- Request a change in individual directing and coordinating our treatment, if you so desire.
- Receive services in an environment that is free from all forms of abuse, including but not limited to: financial exploitation, physical abuse and punishment, sexual abuse and exploitation, psychological abuse such as humiliation, judgement, neglect, retaliation, threats, etc., and all forms of seclusion and restraint.
- Have information about your treatment and your confidentiality is protected to the greatest extent allowed by federal and state confidentiality laws and regulations.
- Have family members, friends, or others involved in your treatment process with consent and approval.
- File a grievance or complaint about the services you receive without fear of retaliation or reprisal of any sort.
- Receive services that comply with all applicable federal and state laws and regulations.
- File a grievance with an outside third party if you feel that the organization has not satisfactorily addressed any concerns you have or does not adequately address any formal grievances you submit.
- To request a transfer to another program if you believe that you are not receiving care that is meeting your needs and preferences.
- You may have additional rights afforded to you based on federal, state, and local regulations
- To be informed of the benefits, side effects, and risks of psychotropic medications in a manner and league that you can understand.

Rights and Responsibilities Client Contract:

Your signature below indicates that you have read and understand this information and have received a copy of the client rights and responsibilities form.

_____

Printed Name of Client Date

_____

Signature of Client Date

_____

Printed Name of Parent/Guardian (if applicable) Date

_____

Signature of Parent/Guardian (if applicable) Date

Authorization

This authorization is valid for one calendar year. It will expire on _____[*insert date*]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

Parent Signature Date

_____

Student Signature* Date

School Authorization Form

Patient/Student Name: _____**Date of Birth**: _____

I hereby authorize the staff of Refocus Counseling to enter my child's school and provided services in the school setting. In addition, I authorize to release or obtain confidential information to and from my child's school staff to include counselor, social worker, teacher, administration etc…

_____Refocus Counseling_____

and _____ [*insert name & title of school official*] will be allowed to exchange health and education information/records for the purpose listed below.

_____ [*insert address & telephone of school/school district*]

_____ [*insert address and telephone of health care provider*]

Purpose: This information will be used for the following purpose(s):

1. Assessments
2. Psychological Evaluations
3. Treatment Planning and Summary
4. Participation in treatment
5. Toxicological Reports/Drug Screens
6. Discharge/Transfer Summary
7. Demographic information
8. Diagnosis
9. Current treatment updates
10. Educational evaluation and program planning
11. Progress in treatment
12. Health assessment and planning for health care services and treatment in school.
13. Medical evaluation and treatment
14. Other:_____
    ___
    _____
    ___

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information