

Welcome to Cognitive Restructuring!

We are happy you chose us to be your Service Provider!

Please fill out the following questions and let the staff know if you have any questions.

Your clinician will be with you shortly.

Thanks very much!

Cognitive Restructuring LLC
707 North 7th Ave, Ste #D
Pocatello, Idaho 83201
208-242-3044 (Phone)
208-904-0494 (Fax)

Client Support Sheet

Client Name: _____ Phone: () _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____ Social Security Number: ____-____-____ Age: ____ Gender: ____
Date Completed: _____ Employer/School: _____
Emergency Contact Name: _____ Phone: () _____ Relationship: _____
Emergency Contact Name: _____ Phone: () _____ Relationship: _____
Legal Guardian/POA Name (If applicable): _____ Phone: () _____

Outside Agency Contacts:

	Phone: ()	Email:	Y	N	Date:	Faxed:	Y	N	Refused	None
Counselor/Therapist:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Case Manager:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Peer Support Specialist:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Psychiatrist/Psychologist:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Primary Care Physician:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Probation Officer:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Family Member:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other Medical Provider:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Primary Insurance Company _____ Member ID # _____ Group# _____
Insurance Company _____ Member ID # _____ Group# _____

Reason(s) for starting Services: _____
Comments: _____

Cognitive Restructuring, LLC

Protections under HIPAA and Omnibus Rule 9-23-2013

Name: _____ Date: _____

Information Line: 1-800-368-1019

Access to Medical Records

Clients may have access to medical records to copy and amend or request amendments
Access will be provided within 30 days of client request for their file review
Is permissible to charge client for copying and sending costs

Request an Accounting of Record

Client may request a listing of records of individuals that personal information was shared with

Privacy

Clients signs or initial or otherwise acknowledges written document of how their health information is to be used
If client does not agree they can disagree to any of the reasons

Limit Use of Medical Information

Even when disclosure is given by client, release minimal information to meet the purpose

Prohibition on Marketing

Can use client success for marketing with client permission of specific authorization of what will be disclosed

State Law Strength

Reporting based on state law does not violate HIPAA regulations

Confidential Communication

Client can request to ONLY be called at work and must be reasonably accommodated

File Complaints

On-line at <http://www.hhs.gov/ocr/hipaa> or by calling (866) 627-7748

Complaints can be filed with provider or with Office for Civil Rights, above

Training

Entities must train personnel in privacy and designate a person responsible to ensure procedures are followed
Disciplinary action by the entity must be taken when personnel fails to follow procedures

Public Responsibilities

Entities may continue to disclose for public responsibility based on judgment and entity policy

Identification of a body of a deceased person

Cause of death

Communicable disease reporting or to avert serious threat to health or safety

Limited data or has been approved by Institutional Review Board or privacy board

Oversight of health care system

Judicial and administrative proceedings

When required by military; command authorities if client in military

For persons in police custody to protect safety and security of correctional institution

Limited law enforcement activities

Workman's Compensation information needed to complete claim process

To business associates within the entity structure

Injury or disability

Abuse or neglect

Provide information about a crime

Activities related to national security

To locate or apprehend a suspect, fugitive, or missing person

Report a crime on the premises and if entity is responding to an emergency report crime information

Equivalent Requirement for Government

Rules apply to private and public entities

OMNIBUS Rule updates: Clients may opt out of fundraising, can limit disclosure to insurance company if pay in cash, has the right to be notified of breach of health record information, to not have health information sold or marketed, to have health records safely stored, to be able to view Notice of Privacy Policies, and to have hard copy and digital records safeguarded within HIPAA compliance.

Client/Parent/Guardian Signature

Date

Provider Choice List

Cognitive Restructuring, LLC

(Circle choice of provider)

Mental Health	Drug and Alcohol
<p>Cognitive Restructuring, LLC</p> <p>A New Way Inc., AAA American Healthcare LLC, Access Point Family Services Inc., Adult and Child Development Center, Allies Family Solutions, Bannock Youth Foundation, Behavioral Treatment Center, Benjamin Douglas, Bright Tomorrows, Candlewood Family Counseling Center Inc, Cassia Morton, Center Counseling Services, Community Mental Health Services, Community Wellness Center Inc., Consumer Care LLC, Crete Brown, Gateway Counseling Inc., Health West Inc., Healthy Place Counseling Pocatello, Hope Tree Inc., Jodyne Bilstrom, Joshua D. Smith and Associates, Life Change Associates, Mental Health Specialists, High Country Behavioral Health, Natasha Cutler, New Horizons Mental Wellness Clinic, Pacific Rim Consulting LLC, Physicians Mental Health Services, Pocatello health Services LLC, Portneuf Valley Family Center, Psychological Assessment Specialists, Shoshone Bannock Clinic, Stacy Pray, T Help LLC</p>	<p>Cognitive Restructuring, LLC</p> <p>A New Way Inc.</p> <p>Bannock Youth Foundation- MK Place</p> <p>Consumer Care LLC</p> <p>Gateway Counseling Inc.</p> <p>Joshua D. Smith & Associates</p> <p>Pacific Rim Consulting LLC</p> <p>Portneuf Valley Family Center Inc.</p>

I understand there are many providers in the area, and I am free to choose my provider. I also understand that I may change providers at any time.

Client/Guardian Signature

Cognitive Restructuring, LLC

Client Rights and Responsibilities

- You have the right to be treated fairly, with dignity, and with respect for your right to privacy. This includes refusing to be recorded, videotaped, or photographed.
 - To refuse to be part of research study without permission
- You have the right to receive all health care services in a caring, non-judgmental way.
- If you have a disability you have the right to receive information in a style that meets your needs.
- The term “Client” may, as appropriate, include family members (release of information exchange required for adult clients), a court-ordered legal guardian, or designated representative in an activated advance directive.
- You have the right to get health care services in a way that respects your culture, race, color, age, disability, religion, gender, gender identity, sexual orientation, physical characteristics, or veteran status.
- This includes getting you an interpreter if you do not speak English.
- You have the right to take part in all health care decisions. This includes treatment and recovery planning. You also have the right to refuse treatment.
- You have the right to have and take medications prescribed by a physician.
- You have the right to understand any treatment you agree to receive. This is called informed consent.
- You have the right to choose someone to help with care choices.
- You have the right to get a second opinion from a provider at no cost. You can get a second opinion when you:
 - Need more information about a treatment.
 - Think the agency or care provider is not providing the right care.
- You have the right to make a complaint about the care you are receiving. This is a way to take charge of your recovery. Complaints can be made about the agency, a care provider contracted with the agency, or anything else about your treatment experience.
- You have the right to choose your care providers from the agency.
- You have the right to have a psychiatric advance directive (PAD). A PAD is a legal document you can use to manage your mental health treatment and wellness if you cannot make or communicate decisions about your treatment. A PAD can say which people you do or do not want to make choices for you.
- You have the right to see your own behavioral health treatment records. This is based on federal and Idaho laws and rules. You have the right to restrict who sees those records based on those laws and rules. You have a right to make amendments to records to correct errors or inaccuracies.
- You have the right to ask for and get information about the agency. This includes its services and how to access them.
- You have the right not to be bothered by either side if problems come up between the agency and its personnel.
- You have the right to not be restrained or secluded based on federal or state rules on the use of restraints and seclusion.

Client Responsibilities are on the next page.

Cognitive Restructuring, LLC

Client Rights and Responsibilities

- The agency asks that every Client is aware of the following responsibilities:
- You are responsible for providing the agency and the care providers with information needed to provide quality care.
- You are responsible for understanding your health problems to the best of your ability. You are responsible for participating in treatment and recovery goals both you and your care providers agree on.
- You are responsible for following these treatment and recovery plans to the best of your ability. You must let providers know if changes are needed.
- You are responsible for keeping, changing, or cancelling appointments instead of not showing up.

Client/Parent/Guardian Signature

Date

Cognitive Restructuring, LLC

Information Disclosure and Consent

Date:

Client Name:

Parent

Guardian

Name:

Confidentiality: The confidentiality of all client records maintained by this program is protected by Federal Law and Regulations. Violation of the Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Generally, the program may not say to any person outside the agency that a patient attends a program or services, or disclose any information identifying a client. Information may only be disclosed under the following circumstance(s):

- 1) The Patient consents in writing;
- 2) The disclosure is allowed by a court order or subpoena; or
- 3) The disclosure is made to medical personnel for research, audit or program evaluation.

Client Information disclosed to a licensed counselor is a privileged communication and cannot be disclosed in any or criminal court proceedings in Idaho without the consent of the client. However, under the Idaho Rule of Evidence 517(d) there is no privilege for the following acts:

Civil Action: In a civil action case or proceeding by one of the parties to the confidential communication against each other.

Proceedings for Guardianship, Conservatorship, and Hospitalization: As a communication relevant to an issue in proceedings for the appointment of a guardian conservator for a client for mental illness or to hospitalize the client for mental illness.

Child Related Communications: In a criminal or civil action or proceeding as to a communication relevant to an issue concerning a physical, mental, or emotional condition of or injury to a child, or concerning the welfare of a child including, but not limited to abuse, abandonment or neglect of a child. Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Licensing Board Proceedings: In the action, case, or proceeding under Idaho Code 54-3403. Individual licensure laws may require the release of confidential information in the event that there is imminent danger of harm to self or others.

Contemplation of a Crime or Other Harmful Act: If the communication reveals the contemplation of a crime or intention to commit a harmful act.

Insurance, Medicaid, and Other Payment Companies: Information needed for billing purposes.

Prohibition of Re-Disclosure Statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by rules (42 C.F.R. Part 2.) A general authorization for the release of medical or other information is not sufficient for this purpose. The federal

Cognitive Restructuring, LLC

Information Disclosure and Consent

rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse of patient. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal Regulations).

When Information May be Shared Without Your Permission: For public health risks, as required by law, emergency treatment, or to prevent a serious threat to health and safety of others.

Release of Information: Information pertinent to care and treatment may be released to insurance companies, other entities for reimbursement purpose, as well as others indicated on signed releases, to be updated at least annually. In regard to individuals court ordered to treatment or have probation officers: Information may be required to report such as substance use, attendance, or rule violations.

HIPAA Notice of Privacy: We are dedicated to protecting your confidential information. We create records of the services provided and forwarded copies of records provided by other service providers. We are required to use and disclose confidential information as required by law, maintain the privacy of your information, give you this notice of our legal duties and privacy practices for your information, and to follow the terms on the current HIPAA guidelines that are currently in effect.

HIPAA Regulations: I understand my rights regarding my private health information and have been provided a copy of the HIPAA laws and have been provided with contact numbers should I have a complaint regarding the use of my child's or my health information.

Right to Review and Copy: You have the right to review and copy your clinical information as allowed by law. You may request any documentation completed by Cognitive Restructuring, LLC Information provided by another agency or entity will need to be requested from that agency or entity.

Right to Amend: You have the right to ask to make changes to your information if you feel the information, we have is incorrect or incomplete. A Request of Amend Records form is available for your use. You must complete the form and return it to the front office for processing. Our office will respond to your request within 10 days. We may deny your request if you ask us to change information when the document was not created in our office, when the information is derived from a court document, when the data is historical in nature and is from the perspective of a biological family member or a member within the family, when we determine the information in court ordered mental health assessment completed by a clinician is an objective cultural representation of the clients current mental health information and/or diagnosis currently at this time.

Emergency or Crisis Plan: Please call our number anytime. Our answering machine will give you the 24 hour on-call number; which you may call in the case of an emergency. In the event of no response, call 911 or go to your local hospital.

Complaints: If you believe your privacy rights have been violated, you may file a written complaint with our office. All complaints turned into our office must be in writing.

Right to Refuse: Treatment may be refused, or consent revoked at any time, if desired by the client. There are many providers from which to choose. Cognitive Restructuring, LLC is only one of those providers.

Length of Treatment: Will depend upon types of issues and concerns present as well as motivation for goal attainment. Average length of time in treatment is between six months and one year.

Infractions: In the event that an entire week is missed of treatment, this will be documented in your file and as probation and parole officers are contacted weekly, a report of no attendance for that week will be given. In the event, that two weeks of no attendance, discontinuation of services may result.

Special Commitments and Instructions for Groups:

Client agrees and commits to attend groups as collaboratively agreed upon.

Client agrees to attend all groups and individual sessions sober.

Client agrees to notify Cognitive Restructuring, LLC and other overseeing professionals if groups are missed.

Client agrees to laws of confidentiality and failure to abide by confidentiality regulations will constitute dismissal from group.

Cognitive Restructuring, LLC

Information Disclosure and Consent

Documentation: Documentation is maintained regarding the services received. You have the right to access your records. These records are confidential and cannot be released without client consent, a court order, or during a state or federal audit.

Professional Standards: Professionals adhere to the National Association of Social Workers Code of Ethics. The Bureau of Occupational Licensing regulates the practice of professionals. The licensure of an individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of treatment.

Second Opinion: Any time in treatment, client may seek a second opinion. This is the responsibility of the client to choose the provider. The client may terminate services at any time unless treatment is court ordered.

Risks: Treatment is not guaranteed to cause positive results. Risk of treatment may include a worsening of behaviors or conditions preceding potential improvement. Lack of treatment or discontinuation of treatment may also lead to worsening of behaviors or conditions that may deter potential improvement.

Alternatives: There are alternative or additional treatments that may be beneficial such as individual counseling, medication management, religious and cultural services.

Emergency Medical Care: I give Cognitive Restructuring, LLC who is the representatives of the above-named individual, consent for any and all necessary emergency medical care for me or my child when client is within the agency's care. I give permission to share with medical personnel necessary information to protect me or my child immediate emergency health risks.

Fees: Portions of rendered services may be covered by insurance, Medicaid, or others. If you do not have insurance coverage or services are not covered by your insurance company, fees may be paid for privately at the following fee schedule:

<i>Selection of Service Choice "x"</i>	Services Offered:	Description and Goal of Service:
	Anger Management	6 sessions, helping the individual in learning techniques of emotional regulation.
	Case Management	Assisting Drug and Alcohol clients to access appropriate services and maintain sobriety.
	Drug and Alcohol Outpatient or Intensive Outpatient Treatment	Helping individuals work toward sobriety and high functionality in all 6 dimensions of treatment and to enhance quality of life. Hours: 8 am to 8 pm.
	Drug Testing	On-site drug testing for individuals involved in Drug and Alcohol Treatment.
	DUI Assessment and Education	12-hour education using MRT Driving the Right Way, CBT, Motivational Interviewing, and safety planning
	Parenting Support	Helping care givers in learning techniques of attachment and interactions
	Community Based Rehabilitation Services	Individual behavioral skills training and community reintegration designed to help the individual gain the optimal level of independent functioning.
	Individual Psychotherapy	Helping the individual in their search for understanding and resolution.
	Peer Support Services	Individual skills recovery-focused approach promoting the development of wellness self-management, personal recovery, natural supports, coping skills, and self-advocacy skills.

Cognitive Restructuring, LLC

Information Disclosure and Consent

Selection of Service Choice "x"	Other Choice of Services:	Description and Goal of Service:	Payment Schedule
	Cognitive Self Change	Stage 1 and/or 2 Idaho Model	\$25 per group
	MRT	12 Step interactive program with homework	\$50 per group
	Drug and Alcohol Education Only	2-12 hours education	\$25 per group \$50 for ½ hour individual
	Other:		
Service		Payment Schedule <i>(costs are subject to change)</i>	
All Services if Private Pay/Self Pay are to be paid by Money Order or Cash in advance			
Anger Management	\$160.00 for 8 sessions		
Comprehensive Diagnostic Assessment	\$180.00		
Community Based Rehabilitation Services	\$45.00 per hour or Medicaid funded program		
Drug and Alcohol Outpatient or Intensive Outpatient Treatment	\$25.00 per group \$50.00 for an individual session ½ hour. \$100.00 for an individual session 1 hour. <i>Reduced rates may be available for individuals upon consultation with billing department.</i>		
Drug Testing	\$15.00 per test		
DUI Assessment	NOT AVAILABLE – REFER OUT		
Gain Assessment	\$180.00		
Mental Health Intake	\$110.00 for Intake if private or self-pay		
Individual Psychotherapy	\$55.00 for an individual session ½ hour. \$110.00 for an individual session 1 hour. <i>Reduced rates may be available for individuals upon consultation with billing department.</i>		
Parenting	\$160.00 for four-week class		

Cognitive Restructuring, LLC

Information Disclosure and Consent

Please indicate the following statements that pertain to you:

	I do not have insurance coverage and I agree to pay the fees for services I receive.
	I have insurance coverage. I give Cognitive Restructuring, LLC Permission to bill my insurance for services I am receiving. I agree to pay the balance of my account that is not covered by my insurance.
	I agree to pay the amount of my co-pay at the time of services.

I understand that I may receive services from a Trainee under supervision. I consent to being treated by a Trainee and understand that I may request a QP for my treatment.

I understand my rights and have asked any questions regarding the above information. I willingly agree with the content of this document and consent to treatment through Cognitive Restructuring, LLC with the understanding of the previously stated disclosures.

Client/Guardian Signature

Date

Personnel Signature

Date

Cognitive Restructuring, LLC

Client Email/Texting Informed Consent Form

Page 1 of 2

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
- c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- d. Employers and on-line services have a right to inspect emails sent through their company systems.
- e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- f. Email and texts can be used as evidence in court.
- g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

Cognitive Restructuring, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Cognitive Restructuring, LLC is not liable for improper disclosure of confidential information that is not caused by Cognitive Restructuring, LLC intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

- a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
- d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
- e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
- f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
- g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Cognitive Restructuring, LLC
Client Email/Texting Informed Consent Form

3. Client Acknowledgement and Agreement

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between Cognitive Restructuring, LLC and me, and the conditions and instructions outlined, as well as any other instructions that my Provide or Therapist may impose to communicate with me by email or text.

Please mark only 1 choice below by initialing:

_____ I **wish** to be contacted by email at the following email address:

Email: _____

_____ I **wish** to be contacted by text at the following phone number:

Phone: _____

_____ I **do not wish** to be contacted by email or text by Cognitive Restructuring, LLC

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Cognitive Restructuring, LLC

Employee Signature: _____ Date: _____

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

Page 1 of 2

1. Risk of using electronic devices for services:

The transmission of member information by electronic device or telephone has a number of risks that members should consider prior to the use of electronic device or telephone. These include, but are not limited to, the following risks:

- a. Information can be circulated, forwarded, stored electronically and broadcast to unintended recipients.
- b. Senders can easily misdial or send the information to an undesired recipient.
- c. Electronic devices may create backup information even after the sender and/or the recipient has deleted his or her copy.
- d. Electronic devices may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of electronic media for sessions:

Cognitive Restructuring, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of all sessions done by any staff member. Cognitive Restructuring, LLC is not liable for improper disclosure of confidential information that is not caused by Cognitive Restructuring, LLC intentional misconduct. Members/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

- a. Electronic media may not be appropriate for urgent or emergency situations. Cognitive Restructuring Provider cannot guarantee that any particular email and/or telephone voice mail will be read and responded to within any particular period of time.
- b. Cognitive Restructuring will make every effort to provide services to a member at a prior designated and scheduled time unless the member requests an immediate session.
- c. A note of the session will be placed in the member record.
- d. Provider will not forward member's/parent's/legal guardian's identifiable emails and/or texts without the member's/parent's/legal guardian's written consent, except as authorized by law.
- e. Provider is not liable for breaches of confidentiality caused by the member or any third party.
- f. It is the member's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.
- g. Member will receive an email and will reply to the email by typing their name as instructed and this will constitute an agreement when a signed document cannot be completed in person.

Cognitive Restructuring, LLC

TeleHealth Informed Consent Form

3. Client Acknowledgement and Agreement

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the services provided by electronic device or telephone between Cognitive Restructuring, LLC and me, and the conditions and instructions outlined, as well as any other instructions that my Provider or Therapist may impose to communicate with me by email or text.

Please mark only 1 choice below by initialing:

_____ I **wish** to receive TeleHealth Services provided by Cognitive Restructuring, LLC

_____ I **do not wish** to receive TeleHealth Services provided by Cognitive Restructuring, LLC

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Cognitive Restructuring, LLC

Employee Signature: _____ Date: _____

Cognitive Restructuring, LLC

Consent to Release and Exchange of Information

Cognitive Restructuring, LLC, will coordinate treatment with other behavioral health practitioners, primary care physicians (PCP's), family and/or other appropriate medical practitioners involved in a member's care. Please complete this form in full and we will send to the appropriate person(s) treating the member.

I, _____, hereby authorize Cognitive Restructuring, LLC
(Parent/Guardian of client or client name)

to request and/or disclose information, verbal or written, of

_____, to _____
(Name of Client) (Name of Agency or Individual – Include Relationship)

(Contact Information Street Address City State Zip)
(Phone) _____ (Company Fax number) _____

*****Please X and initial next to all applicable items requested below (Questions ask Provider).**

The records requested are for the following services:

- | | |
|---|---|
| _____ <input type="checkbox"/> Substance/Alcohol Abuse Services | _____ <input type="checkbox"/> Mental Health Services |
| _____ <input type="checkbox"/> Case Management | _____ <input type="checkbox"/> HIV/AIDs related information |
| _____ <input type="checkbox"/> RSS Services(Other) | _____ <input type="checkbox"/> Legal Services |

*****Please X and initial next to all applicable items requested below (Questions ask Provider).**

Specific Information Requested:

- | | |
|--|---|
| _____ <input type="checkbox"/> GAIN Assessment | _____ <input type="checkbox"/> Admission/Discharge Summary |
| _____ <input type="checkbox"/> Psychiatric Evaluation | _____ <input type="checkbox"/> Court Related Information |
| _____ <input type="checkbox"/> Social/Medical History | _____ <input type="checkbox"/> Case Management Plans/Progress |
| _____ <input type="checkbox"/> History & Physical Exam | _____ <input type="checkbox"/> Treatment Plans |
| _____ <input type="checkbox"/> Laboratory Data(Drug Testing) | _____ <input type="checkbox"/> Exchange Information |
| _____ <input type="checkbox"/> Probation/Parole Progress Reports | |
| _____ <input type="checkbox"/> Medication Records | _____ <input type="checkbox"/> Other: _____ |

Cognitive Restructuring, LLC

Consent to Release and Exchange of Information

The purpose of the disclosure authorized herein is to: _____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed with my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any events this consent expires automatically 365 days post-discharge from the treatment program.

I also understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

Client Signature

Date

Parent/Guardian Signature

Date

Cognitive Restructuring Employee Signature

Date

Behavioral Health-Health Questionnaire

Client's Name:

Today's
Date:

Client's initial explanation of the problem(s), duration and precipitant cause:

Presenting problem/reason for assessment (In client's own words: list of symptoms or concerns of client):

Acuity Check

- | | | |
|----|-----|--|
| No | Yes | Do you have current, severe and/or untreated health problems? |
| No | Yes | Are there any Health concerns you currently have? |
| No | Yes | Do you feel that you are at risk for hurting yourself or someone else? |
| No | Yes | Are you being hurt by someone else or at risk of being hurt? |
| No | Yes | Have you just used any form of drugs or alcohol? When: |

Medical

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

- Community Health Center
- Urgent Care Center
- Dentists
- Private Community
- Physician Pain Management Services
- Methadone Clinics
- Hospital Emergency Rooms
- Specially Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology)

General Health

1. Who is your Primary Care Physician?
2. What was date you were last seen?
3. How many times have you visited an Emergency Room in the past 30 days?
4. How many days in the past 30 have you stayed overnight in a hospital for physical health problems?
5. How many days in the past 30 have you experienced physical health problems?

PERTINENT HISTORY

(Including family, social, psychological and medical) Any prior therapy: Significant childhood developmental history (including mother's pregnancy and delivery, delays in meeting developmental milestones):

7. Significant childhood developmental history (including mother's pregnancy and delivery, delays in meeting developmental milestones):

8. Significant childhood social history (social delays, difficulty making or keeping friends)

9. Psychiatric/Behavioral History:

10. Childhood history (abuse, neglect, trauma):

11. Diagnosis in childhood (by whom, if applicable):

12. Age at onset:

13. Childhood psychiatric hospitalizations: (dates, reasons, symptoms of decompensation, medication):

14. History of any other illness that may require frequent medical attention. Give details:

MEDICAL HISTORY

15. List of Current Medications:

16. Current Medication Allergies:

17. Current Food Allergies:

18. Neurological Disorders (seizures, epilepsy, HI, stroke, Parkinson's, MS, Palsy, etc.):

19. Chronic diseases (HIV, hepatitis, etc.):

20. Remarkable family medical history (diabetes, cancer, heart disease):

21. Out-patient treatment (provider name, dates, modality):

22. Have you had any surgeries?

ADULT HISTORY

23. History of abuse as a perpetrator:

24. Diagnosis (by whom, if applicable):

25. Psychiatric hospitalization (dates, symptoms of decompensation, medications):

26. Out-patient treatment (provider, dates, modality):

27. History of malingering:

CURRENT MENTAL HEALTH DIAGNOSIS

28. (Diagnosis, date, diagnosed by:

FAMILY/PSYCHOSOCIAL ASSESSMENT

29. Family Mental Health History (who, what, when):

30. Family (parents, Siblings, Children, etc.)

31. Current Service providers:

SUBSTANCE ABUSE

32. Indicate if GAIN is recommended:

33. Substance Use History (what, when, frequency, amount, impact on mental health)

34. Family History of drug/alcohol use: (what, when, frequency, amount, impact on mental health)

35. Substance Use Treatment (historical and current treatment, outpatient and inpatient, when, where, duration, outcome, treatment needs):

36. Drugs of choice (indicate C=current/P=past)

37. Current substance use/dependence (what and how often)

Alcohol	Currently	Sometimes	Never
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Illicit Drugs	Currently	Sometimes	Never
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38. Are you in withdrawal today? No Yes If yes, from what substance(s)?

39. Do you have frequent blackouts? No Yes How frequently?

40. Are you currently smoking/ingesting marijuana? No Yes Medical Marijuana Card? No Yes

41. Date last smoked/ingested:

42. Have you ever overdosed on alcohol or other drugs? When?	No	Yes	if yes on what?
43. Do you currently use tobacco? day, # of dips)	No	Yes	if yes, how? Smoking, Chewing, Other How much; (# Packs a
44. Do you currently use a Vape?	No	Yes	% of Nicotine

FUNCTIONAL ASSESSMENT

45. School/Education (current grade attending or highest grade completed/further education. (Diploma, GED, etc.)
46. Current and Previous Employment (full time/part time and names of employers, dates)
47. If unemployed: Currently seeking employment?
48. Military Service (active, inactive, veteran)
49. Needs:

FINANCIAL

50. Sources of Income
51. Skills for managing finances (budgeting, bill payment, etc.):

SOCIAL

52. Interests (leisure and recreational)

53. Support systems and relationships (Clients ability to establish and maintain support systems and relationships)

54. Level of social interaction

55. Needs:

BASIC LIVING SKILLS

56. Skills and abilities to meet age appropriate basic living skills (meal preparation, housekeeping, etc.):

57. Needs:

HOUSING

58. Current housing:

59. Level of satisfaction and stability:

60. History of housing stability:

61. Current Risk of homelessness:

62. Needs:

COMMUNITY

63. Transportation resources:

64. Identify membership in church, clubs, and other groups:

65. Do you have any religious, cultural, physical or other factors that might influence your care?

66. Needs:

LEGAL

67. History of criminal justice involvement (arrests, warrants, parole/probation or jail time):

68. Involvement with CPS:

69. Needs:

70. Are you experiencing any of the following: (Circle all that apply)

Ankles Swollen Bleeding Problems, Bruising easily Chest pain(angina) Cough; persistent or bloody Diarrhea, constipation, blood in stools Dizziness or fainting Fever	Headaches Jaundice-frequent yellowing of skin Joint pain or stiffness Excessive heartburn or Abdominal pains Chronic back pain Nausea and vomiting Rashes Seizures	Shortness of breath Sinus Problems Swallowing difficulty Thirst excessive Tooth or gum problems Urination frequent or bloody Vision-blurred or double vision Weight gain
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71. Do you have or have you had any of the following: (Circle all that apply)

Arthritis Artificial Joint Asthma Emphysema Chronic bronchitis	Diabetes Anemia Blood Transfusions Cancer	Chemotherapy/Radiation High Blood Pressure Low Blood Pressure Stroke – if yes give details:
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72. No Yes Head injury resulting in loss of consciousness? If yes, give details:

73. No Yes Heart Attack or Heart Problem? If yes, give details:

Date of heart attack:

Medical Interventions such as bypass, stint, etc.:

74. Women Only

No Yes Are you pregnant? Due Date: No Yes Breast feeding? No Yes Have you had any miscarriages or abortions? No Yes Do you have difficult periods? What age did you start your first period?	Date of last period? No Yes Any current or past domestic abuse? No Yes Do you have pain with intercourse? No Yes Abnormal mammogram or lump? Date: No Yes Abnormal PAP? Date: Date of last GYN exam:
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75. Communicable Diseases

No Yes Have you ever been tested for TB? No Yes Have you ever had a positive TB test? Date of last TB test or chest X-ray:

No Yes Have you been diagnosed with Hepatitis C? Date of last test: No Yes Have you been tested for any other liver disease? Specify:
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No Yes Have you been diagnosed with a Sexually Transmitted Infection (STI)? No Yes Did you get treated? Date of last STI test:

Been tested for HIV? No Yes	Did you receive the test result? Been tested for HIV?	Date of last HIV Test?
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Mental Health

76. How many times in the past 30 days have you received outpatient emergency services for mental health?

77. How many days in the past 30 have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs?

78. No Yes In the past 30 days, have you taken prescribed medication for mental health needs, (including medication for anxiety-list on question 15).

79. Past suicide attempts?
No Yes

80. Date of most recent attempt:

81. How many attempts in your lifetime?

To the best of my knowledge, the above information is accurate and true, and I will inform my provider of changed in my health or medications:

Client Signature: _____ Date: _____