Client Chart Order Check List

☐ _____ Client Chart Billing Log (always on top)

☐ _____ Completed Treatment Plans and Signature Pages on first tab
(Treatment Advocate Forms with each Signature Page when applicable)

✓ Initial

☐ _____ Chart Order Check List
☐ _____ Referral Form
☐ _____ Client Handbook (given to client/guardian)
☐ _____ Consent for treatment
☐ _____ Consent to Bill Private Insurance (when applicable)
☐ _____ Release of Information (if applicable)
☐ _____ HIV Form
☐ _____ Client Orientation/Acknowledge Check List
☐ _____ Fee Schedule
☐ _____ Court Action Fee Agreement
☐ _____ Outpatient telehealth form

✓ Initial

☐ _____ Bio psychosocial Attestation (telehealth only)
☐ _____ Bio psychosocial Packet
☐ _____ Screeners (Trauma, SI/Self-Harm, Depression, etc)
☐ _____ Transitional Plan
☐ _____ ACE Screener (for 18+)
☐ _____ Card Authorization Form (pull from chart/scan to TheraNest and shred) *Priv. Ins. Only

Other Forms:

☐ _____ Testing Reports

☐ _____ IEP/504 Plans or Attestations

☐ _____ Other: _____

Integrated Therapy Solutions of Oklahoma, LLC
620 N.W. 5th St. Suite. D
Moore, OK 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

TRANSITION PLAN

Client's name _____ Insurance# _____ Admit date _____

How will you know that you are nearing completion of services and ready to transition into your community? (to be asked of client at assessment- direct quote required):

_____

_____

Below this line to be completed at Discharge:

Progress (In client's own words): _____

_____

Gains (In client's own words): _____

_____

Strengths/abilities _____

_____

Needs/liabilities _____

_____

Presenting problem (from intake) _____

_____

The following care services have been developed with my knowledge and cooperation. My response regarding these plans is as follows: _____

_____

_____

Referral Source: (Name, contact information, agency, hours available)

_____

_____

_____

Below this line to be completed at Discharge:

_____ _____

Client Signature (if over 12) **Date**

_____ _____

Guardian Signature **Date**

_____ _____

Therapist Signature & Credentials **Date**

INTEGRATED THERAPY SOLUTIONS OF OKLAHOMA, LLC

CONSENT FOR TREATMENT

1. I, We (Parent, legal guardian if applicable) authorize **Integrated Therapy Solutions of Oklahoma, LLC** and representative mental health and substance abuse providers to administer treatment to me and to continue such treatment as deemed professionally necessary.
2. I/We do hereby authorize psychiatric, psychological, diagnosis or treatment by a physician, therapist and /or authorized mental health provider by **Integrated Therapy Solutions of Oklahoma, LLC.** Treatment may be rendered to said client under general, specific or special consent of **Integrated Therapy Solutions of Oklahoma, LLC**, whether such diagnosis or treatment is rendered at the office of the psychiatrist, therapist, or provider**.** I understand that this consent is given in advance of any specific diagnosis of treatment being required, but is given to encourage and authorize those persons, (physicians, providers) to exercise their judgment as to the requirements of such diagnosis or psychotherapeutic treatment.
3. I/We further agree to be actively involved in the treatment plan as prescribed by the treatment team of **Integrated Therapy Solutions of Oklahoma, LLC** while the client is in treatment. I/We understand that included in such treatment plan would be my/our involvement in regular family, individual, or group therapy sessions, scheduled in accordance with State, Federal and/or pay or source guidelines.
4. No guarantees or assurance have been given by anyone to the results that may be obtained.

This consent shall remain in effect commencing on the date of admission to **Integrated Therapy Solutions of Oklahoma, LLC** unless sooner revoked in writing and delivered to said physician, therapist, or provider of **Integrated Therapy Solutions of Oklahoma, LLC.**

By signing below, I/we understand and agree to the following:

I/We understand that **Integrated Therapy Solutions of Oklahoma, LLC** provides these services regardless of the client's ability to pay. If able I/we agree to pay when services are rendered and charged.

I/We have read the Consent for Treatment form, understand all its content and sign my/our name(s) here freely, voluntarily and without coercion.

I/We agree to give 24-hour notice of cancellation if not participating in planned services and understand that by *consistently* not showing up for planned services, the treatment plan may be reviewed by treatment staff to determine the appropriateness of continued treatment or discharge.

I/We have provided the information in the Initial Intake Packet and, upon review, find it to be accurate to the best of my/our knowledge.

I/We have read and received the Privacy Practice Notice Forms and this information been discussed with me, and I/we understand how my health information will be handled and used through **Integrated Therapy Solutions of Oklahoma, LLC.**

I/We have read and received the Client Grievance Policy and Procedure Form and has been discussed with me, and I/we understand that if there is a grievance I/we may file a complaint with the Grievance Officer.

_____ _____

Signature of Client (if 14 years or over) **Date** **Signature of Parent/Guardian** **Date**

_____

Signature of Staff with Credentials **Date**

01.05.2025

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D. Moore, OK 73160
Phone: (405) 208-4469 **Fax:** (405) 208-4472

Consent to Bill Private Insurance

By signing below, I/we understand and agree to the following:

Consent for Release of Information:

I hereby voluntarily consent for Integrated Therapy Solutions of Oklahoma, LLC to submit claims to My Health Care Insurance Company for billing purposes and coverage.

I authorize the release of any medical or other information from Integrated Therapy Solutions of Oklahoma, LLC to process insurance claims to my insurance company, for billing purposes and coverage.

Authorize Payment:

I authorize payment of medical benefits to Integrated Therapy Solutions of Oklahoma, LLC by my Health Care Insurance Company, for mental/behavioral health services provided.

Payment Responsibility:

I understand that I am responsible for keeping my insurance active.

I understand that late cancellations/missed appointment fees are not covered by insurance.

I understand that court-related services are not covered by insurance and have a base rate of $200/hr.

I understand that health insurance companies require a diagnosis in order for them to cover service fees. If you have met your deductible (according to your insurance company) you will only pay your usual co-pay amount. If you have not reached your deductible (according to your insurance company), you will pay the full session fee at the time of the session, and that amount will be added to help you reach your deductible. At first contact, Integrated Therapy Solutions of Oklahoma, LLC can help you determine what your copay may be but be aware that insurance companies cannot guarantee what they will cover ahead of time.

Please understand that if you do have secondary insurance and don't provide the information, the first insurance company can demand a refund of what they have covered, in which you will be responsible for covering that cost. There is no guarantee that the secondary with cover that cost.

I agree to provide Integrated Therapy Solutions of Oklahoma, LLC with a credit/debit card to keep on file to bill co-pays; I consent to the billing of co-pays through a remote biller. Integrated Therapy Solutions of Oklahoma, LLC agrees to contact me before billing any amount other than the co-pay in the event that insurance does not cover the full amount. ***(with the exception of VA clients which covers at 100%)***

By initialing this box, you acknowledge and understand the terms and conditions described above. THIS IS REQUIRED TO RECEIVE TREATMENT

_____ _____

Signature of Client (if 14 years or over) **Date** **Signature of Parent/Guardian** **Date**

_____

Signature of Staff with Credentials **Date**

 Client Name: _____

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
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CLIENT ORIENTATION REVIEW & ACKNOWLEDGEMENT

I/we received the Integrated Therapy Solutions of Oklahoma, LLC Client Handbook, and reviewed it with the intake counselor. By signing below, I/we acknowledge that I/we have reviewed each area below and asked questions as needed to fully understand each section and subject below.

Consent for Follow Up

I, _____ (Patient, Parent/Legal Guardian if applicable) authorize Integrated Therapy Solutions of Oklahoma, LLC to contact me by phone/mail/in person for the purpose of evaluation of treatment progress, service satisfaction and other information as deemed necessary in order to enhance the quality of care. ☐ **Yes** ☐ **No**

By signing below, I/we understand and agree to the following:

I/We agree to notify the agency in advance if unable to keep a scheduled appointment.

I/We agree to notify the agency of any changes to my address or phone number.

I/We understand that missing *three consecutive scheduled appointments* may result in discharge.

I/We have received the synopsis of the Consumer Bill of Rights in the Client Handbook.

I/we acknowledge that failure to provide appropriate insurance information, including coverage other than SoonerCare will result in full financial responsibility for any sessions and services accrued.

****Requests for court-related services may incur additional costs as they are not SoonerCare approved services. These services have a base rate of $200 PER HOUR.**

Medical Records Requests: Base rate is $25 for the first 75 pages and $0.10/per page after + cost of mailing (if requested). Invoice must be paid in full before request is processed.

_____ _____
Signature of Client, 12 and older **Date** **Signature of Parent/Guardian (if applicable)** **Date**

_____
Signature of Staff with Credentials **Date**

Client Acknowledgement of
HIV/A.I.D.S./STD & TB EDUCATION & REFFERAL

Integrated Therapy Solutions of Oklahoma, LLC offers information and referral for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD), and Acquired Immunodeficiency Syndrome (AIDS) and Tuberculosis (TB). Information/Education/Referral is for consumers, all drug dependent persons, and the significant other(s) of the consumer(s). Documentation of this is either by acknowledgement of Client Handbook or Clinical Consultation note in the consumers record. Referral and documentation is confidential.

CONFIDENTIAL AND ANONYMOUS COUNSELING AND TESTING SITES IN OKLAHOMA:

HIV/STD: GUIDING RIGHT * 7901 NE 10th, Suite A-111 in Midwest City, OK 73110 * 405-733-0771

RAIN Oklahoma * 600 NW 23rd , Suite 101 in Oklahoma City, OK 73103 * 405-232-2437

RED ROCK BH SCIENCES * 4400 N. Lincoln Blvd in Oklahoma City, OK 73105 * 405-425-0473

COMMUNITY HEALTH CENTER * 12716 NE 36th in Oklahoma City, OK 73140 * 405-769-3301

TB: OKLAHOMA COUNTY HEALTH DEPT. * 400 NE 50th in OKC, OK 73105 * 405-419-4000

MED-EVAL CLINIC * 4001 N. Classen Blvd, #101 in Oklahoma City, OK 73118 * 405-840-2180

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION BY CLIENT:
(Both lines must be completed – N/A on Significant Other if needed)

_____ I, (and my significant other, if applicable) have received the HIV/A.I.D.S./STD & TB Education Information and have been offered referrals for testing for these conditions.
_____ I, as the significant other of _____, have received the HIV/AIDS/STD & TB Information and have been offered referrals for testing for these conditions.

I DO WISH to be referred* for testing for (circle as many as desired): **HIV/A.I.D.S – STD – TB**
* Client was referred to: _____
* Significant other was referred to: _____

-- OR -- (Both lines must be completed – N/A on Significant Other if needed)

____ I DO NOT WISH to be tested or referred for **HIV/A.I.D.S./STD & TB (client)**
____ I DO NOT WISH to be tested or referred for **HIV/A.I.D.S./STD & TB (significant other)**

Acceptance of this form in the client record indicates that this Integrated Therapy Solutions of Oklahoma, LLC client has received basic HIV/A.I.D.S./STD/TB prevention education.

_____ _____ _____
Client/Guardian Signature Date Significant Other (if applicable) Signature Date

_____
Therapist Signature with Credentials Date

05.2023

Integrated Therapy Solutions of Oklahoma, LLC

Release of Confidential Information

I understand that medical records requested are protected under the Federal and State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for in the regulations. State and Federal laws and regulations prohibit any further disclosure without the specific written consent of the subject or as otherwise permitted by such regulation. I also understand that the signing of this consent may be revoked **(in writing to program coordinator or designee)** at any time unless action has already been taken based upon it and that in any event this consent expires one year from the date of signature.

I, _____ Request That Information Concerning: _____
(Name of requesting party) (Print Name of Client)

DOB _____ SS _____

Be released and authorize **from**:
(Name/Agency) (Address) (City, State, Zip)
VA/COMMUNITY CARE _____

To exchange with: Integrated Therapy Solutions of Oklahoma, LLC

620 NW 5th St. Suite D
Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

The following written, verbal and/or electronic information – ***including an explicit description of the substance use disorder information that may be disclosed***: (Kind and/or extent of information to be released)

Dates/times of sessions and session notes as requested for billing/payment purposes

To be release for the following purpose(s):

****This is a requirement of the VA in order to have continued coverage of services****

I understand that the information I authorize for release may include records which may indicate the presence of a communicable or venereal disease, which may include but are not limited to, substance use or abuse disorders; diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). **The release of information form has been explained to me and the consent has been given of my own free will.**

It has been explained to me that my treatment services are not contingent upon or influenced by my decision concerning the release of information.

_____

(Signature of client or legally authorized representative) Date

I request this Consent for Release to expire on _____ Client/Guardian Initials _____

_____

(Signature of staff requesting release) Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

Court Action/Legal Fees Agreement

Records Requests – PER CLIENT/PER REQUEST

A charge of up to $10.00 may be collected for administrative costs.
A fee, not to exceed $5.00, for certifying the medical records may also be charged. The cost of postage may also be charged.
Fees for copying documents may be: $25.00 flat rate for the first 100 pages /$0.10 for each page copied in excess of 100 pages

Writing a Treatment Summary - PER CLIENT/PER REQUEST

A flat rate fee of $200 may be charged for each treatment summary requested. We do require 10 business days turnaround when requesting this information.

Court Related Fees: PER CLIENT/PER REQUEST

I/we understand that clients are discouraged from having their therapist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that the testimony will be solely in your favor. Your provider can only testify to the facts of the case and not to any professional opinion. By initialing this line, you acknowledge that your provider's testimony cannot include anything other than fact, per state licensing regulations and acknowledge that your provider is not an expert witness.

I/we acknowledge that if any court involvement is required and the court orders the therapist to participate, or if a subpoena is received for the therapist, or the therapist attendance is requested, the following fees are due ***before*** the therapist will take any action.

The minimum charge for a court appearance: **$1500**
A retainer of $1500 is due 14 days in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 72-hour notice there will be an additional $500 "express" charge.
Additionally, if the case is reset with less than 72 business hours' notice, then the client will be charged $500 (in addition to the retainer of $1500 becoming non-refundable). In order to appear in court, the therapist must cancel sessions and rearrange services for other clients who may not be able to reschedule on short notice.

The following fees apply for court involved cases: (PER COURT APPEARANCE/SUBPOENA)

- Preparation time (including submission of records): $200/hour
- Phone calls/consultations related to the case: $200/hour (with any attorney/GAL, legal representation, DHS case worker, etc.)
- Depositions: $200/hour
- Time required in giving testimony: $250/hour
- Mileage: $0.40/mile
- Time away from office due to depositions or testimony: $200/hour (includes travel time to and from)
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- Additional fees not specifically covered.

I/we understand that non-compliance with the fee schedule or non-payment will result in immediate termination of the counseling relationship and immediate discharge of the client.

I/we have read the Court Action/ Legal Fees Agreement, understand all of its content and sign my/our name(s) here freely, voluntarily and without coercion.

_____ _____

Signature of Client (if 12 years or over) **Date** **Signature of Parent/Guardian** **Date**

_____

Signature of Staff with Credentials **Date**

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D.
Moore, OK 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

FEE SCHEDULE AGREEMENT – PRIVATE INSURANCE

Client Fiscal Responsibility Policy

I understand that I am expected to pay the ***agreed upon fee*** at the time services are rendered.

Proof of income may be required for sliding scale options. (Copy of income tax return or recent pay stub.)

**These are the cash rates charged by ITS of OK and the rates billed to insurance – contracted rates can vary by insurance company.

The fee for intake services is $250.00 per intake.

The fee for psychotherapy services is $200.00 per hour.

The fee for psychosocial rehabilitation and case management is $50.00 per hour.

Group Psychotherapy is $20.00 per person per hour.

Group Psychosocial rehabilitation is $10.00 per person per hour.

*****Requests for court-related services may incur additional costs. These services have a base rate of $200 PER HOUR.***

I understand that I am expected to pay my session fees not covered by insurance, fees due as part of co-insurance or deductibles required by insurance at the time services are rendered – or if a missed appointment fee is charged. Missed session fee: _____

I agree to provide Integrated Therapy Solutions of Oklahoma, LLC with a credit/debit card to keep on file to bill sessions fees AND MISSED APPOINTMENT FEES; I consent to the billing of session fees through a remote biller.

Past Due Accounts: If your account becomes past due, and we have to refer your account to a collection agency, you agree to pay a collection fee of 35% of your delinquent amount. If the collection agency is unable to collect your balance due and pursues litigation, you agree to pay an increased collection fee of 50% of your delinquent amount.

_____ _____

Client/Guardian Signature Date **Staff Signature with Credentials Date**

01.2025 Client Name: _____

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D.
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SAMPLE SLIDING FEE SCHEDULE

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0 percent discount)

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	**Discount 100%**	**Discount 90%**	**Discount 80%**	**Discount 70%**	**Discount 60%**	**Discount 50%**	**Discount 40%**	**Discount 30%**	**Discount 20%**	**Discount 15%**	**Discount 10%**	**Discount 0%**
1	$15,060	$16,566	$18,072	$19,578	$21,084	$22,590	$24,096	$25,602	$27,108	$28,614	$30,120	>$30,120
2	$20,440	$22,484	$24,528	$26,572	$28,616	$30,660	$32,704	$34,748	$36,792	$38,836	$40,880	>$40,880
3	$25,820	$28,402	$30,984	$33,566	$36,148	$38,730	$41,312	$43,894	$46,476	$49,058	$51,640	>$51,640
4	$31,200	$34,320	$37,440	$40,560	$43,680	$46,800	$49,920	$53,040	$56,160	$59,280	$62,400	>$62,400
5	$36,580	$40,238	$43,896	$47,554	$51,212	$54,870	$58,528	$62,186	$65,844	$69,502	$73,160	>$73,160
6	$41,960	$46,156	$50,352	$54,548	$58,744	$62,940	$67,136	$71,332	$75,528	$79,724	$83,920	>$83,920
7	$47,340	$52,074	$56,808	$61,542	$66,276	$71,010	$75,744	$80,478	$85,212	$89,946	$94,680	>$94,680
8	$52,720	$57,992	$63,264	$68,536	$73,808	$79,080	$84,352	$89,624	$94,896	$100,168	$105,440	>$105,440
For each additional person, add	$5,380	$5,918	$6,456	$6,994	$7,532	$8,070	$8,608	$9,146	$9,684	$10,222	$10,760	>$10,760

*Based on the 2024 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.

Client Name: _____

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

OUTPATIENT TELEHEALTH CLIENT INFORMED CONSENT

Telehealth is the use of electronic information and communication technologies by a Mental Health Provider to deliver services to an individual when he or she is located at a different site than the client.

I, _____, agree to participate and receive therapy via the use of a HIPAA compliant platform video telehealth delivery system. I will be receiving mental health services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of mental health care delivery and that my therapist will not be physically in the same room as me.

By signing below, I/we understand and agree to the following:

- I understand that I have the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which I am currently receiving or would otherwise be entitled. I understand that my participation in this is voluntary, and I may decide to terminate my treatment at any time.
- I also understand that there are several benefits of receiving telehealth services that have been identified including increased access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services.
- I understand that there are potential risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist and Integrated Therapy Solutions of Ok, LLC, that the transmission of my telehealth session could be disrupted or distorted by technical failures. Furthermore, with telehealth, I understand there is the risk of being overheard by anyone near me if I do not place myself in a private area and protected from other's intrusion. I understand that I maintain sole responsibility for ensuring the privacy of my surroundings when participating in telehealth sessions. I also understand with any form of mental health services despite my efforts and the efforts of my therapist that my mental health issues may not get better.
- I understand that telehealth is not always appropriate for emergency medical and suicidal ideations and if such emergencies arise, I will be required to seek face to face consultation and evaluation, and by signing this consent, I agree in advance to seek such care if I or my provider deem this necessary.
- I understand that my privacy and confidentiality will be protected in the same manner if I were to receive therapy face to face with my therapist in the same room. I understand that I am responsible for providing a confidential setting in my location. I understand the laws that protect privacy in the confidentiality of medical information also apply to telehealth. As always, OHCA will have access to medical records for quality review/audit.
- I understand that there will be no recordings of my therapy sessions. I also agree to not record my own therapy sessions without my therapist's knowledge or permission.

I give my consent to receive mental health services through a ***telehealth HIPPA compliant platform*** that I agree to use with my therapist. I also understand that the telehealth services I receive will become part of my mental health records.

_____ _____

Client Signature Date Client Parent/Guardian Signature Date

_____

Staff Signature & Credentials Date

Integrated Therapy Solutions of Oklahoma, LLC
620 NW 5th St. Suite D
Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

Telehealth Policy and Procedures

Telehealth Delivery of Mental Health Services

Integrated Therapy Solutions of Ok, LLC offers the ability to deliver mental health services through telehealth.

Definition: Telehealth is the use of electronic information and communication technologies by a Mental Health Provider to deliver mental health services to the client when he or she is located at a different site than the client. Telehealth is not meant to take the place of regular face to face therapy.

Telehealth delivers mental health services using a Secure HIPAA compliant platform.

- Expand the geographical area over which a mental health provider can offer direct service
- Save time and energy without compromising quality
- Allow providers and the client greater flexibility and increased access when delivering or receiving services
- Allow clients to receive needed services without having to travel long distances, when weather and road conditions are problematic.

Eligible Clients

Clients are eligible to receive their mental health services via telehealth when:

- Telehealth is determined an appropriate method of conducting a therapy session.
- The provider is able to document a medically necessary reason for telehealth.
- Client or Client's guardian has signed an Informed Consent agreeing to receive therapy services via a secure HIPAA compliant platform.
- Client has the ability to access the secure HIPAA platform identified for use by the assigned Clinician.

Eligible Providers

Providers currently authorized to provide telehealth services in compliance to OHCA and 3rd party payers.
Guidelines are as follows:

- Clinician must have a current individual contract with client's insurance company.
- Clinician must be employed or under contract with Integrated Therapy Solutions of OK, LLC
- Clinician must have signed the Provider Telehealth agreement Form
- Indicate on the Provider Telehealth agreement Form which secure HIPAA compliant platform will be used.
- Sign a Business Associate Agreement with the HIPAA Compliant Platform to be used.

When delivering services via telehealth, clinicians must do the following:

- Employ strategies to minimize vulnerabilities in technological equipment when conducting sessions via telehealth.
- Ensure procedures are in place to protect client confidentiality
- It is the responsibility of the Clinician to ensure that a HIPAA compliant platform is being used.

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- Ensure that an interactive telehealth system is compliant with HIPAA privacy and security requirements and regulations and meets all policy and procedures from OHCA/DMH/COA/3rd Party Payers.

Non-covered Services

Integrated Therapy Solutions of OK, LLC does not reimburse for connection charges, or origination, set-up or HIPAA compliant platform fees.

Billing

Refer to the following when billing for services provided through telemedicine:

- Services provided via telemedicine have the same service thresholds, authorization requirements and reimbursement rates as services delivered face-to-face.
- Progress Note must be entered using the billing system in the same manner as services delivered face-to-face.
- Client Treatment Plan must include telehealth as a service delivery option, and telehealth must be listed on the service plan signature page.
- Progress Note must indicate for mental health services delivered via telehealth with telehealth billing modifier GT or 95, depending on insurance.
- Progress Note must indicate the place of service code using the EHR's drop down menu that identifies the location of the client when the service was provided. Progress Note must also include that the session was provided via telehealth by clinician in a secure location to protect client confidentiality.
- Progress Note must include medically necessary reason(s) for telehealth.

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household <u>often</u>:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household <u>often</u>:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you <u>ever</u>:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you <u>often</u> feel that:

   No one in your family loved you or thought you were important or special?

   Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you often feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents ever separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   Often pushed, grabbed, slapped, or had something thrown at them?

   Or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   Or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Adverse Childhood Experience (ACE) Questionnaire

PROVIDER INSTRUCTIONS ***(Revised April 11, 2019)***

Beginning June 1, 2019, the ACE Questionnaire shall be given to all adults ages 18 and older* who are seeking behavioral health services from the ODMHSAS and the OHCA (SoonerCare/Medicaid); with minimal exception**. The ACE score shall be reported on all CDC/PA 23 (admissions) and CDC/PA 42 (6-month updates/extensions). The questionnaire only has to be given once per person, per provider- but the score must be reported/carried forward on all subsequent CDCs like some of the other CDC responses (ex: gender and race are typically reported/carried forward on each CDC and rarely change). Valid ACE Scores should be entered on the CDC in one of the following formats: 00 to 10 or 0 to 10 (00 to 10, double digits, is preferred). For currently admitted/open adult clients, the ACE Questionnaire shall be given at the next 6-month treatment update and reported on the CDC/PA 42 (6-month update/extension).

*Note: This questionnaire should only be given to adults ages 18 and older; it should not be given to children or youth under the age of 18.

**Exceptions: Due to the nature of some levels of care and program types, there are circumstances in which the ACE Questionnaire shall not be required. They are as follows:

- *Community Living (CL) Level of Care* (ex: Homeless, Housing, Residential Care)
- *Service Focus*- 11 (Homeless, Housing, Residential Care); 23 (Day School); 24 Medication Clinic Only; and 26 Mobile Crisis.

GIVING THE ACE QUESTIONNAIRE

The ACE Questionnaire is to be given at the time of clinical assessment (at initial clinical assessment for new clients, and for currently admitted/open clients- at clinical assessment update completed as a part of the service plan update process at 6-month treatment update). This is to ensure ready access to a therapist should one be needed to address any issue that might arise from revisiting childhood trauma.

It is a self-administered instrument and shall be completed by the individual seeking services without intervention from staff (ex: staff may not reframe the question or give explanation regarding the intent of the question). The only assistance that staff may provide is with regard to literacy or vision challenges, and in that instance the introduction statement and questions must be read aloud to the individual exactly as written on the questionnaire. To ensure a trauma informed process, it is important that the introduction statement on the questionnaire is either read by the client or read to the client.

Due to the sensitive nature of the questions, the individual completing the ACE Questionnaire should be given a confidential space in which to complete it. They may choose to have someone with them in the room for support (ex: Peer Support Specialist, family, friend).

Scoring

For each of the ten (10) questions on the questionnaire, the individual will give a Yes or No answer. When scoring, each “Yes” answer will be given one (1) point. These points will be tallied to determine the individuals ACE Score.

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date:_____ Time: _____
Start: _____
_____ DO NOT BILL Stop: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the last 2 weeks, how often have you been bothered by an of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide
For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____ x 0=	_____
Several Days	(#) _____ x 1=	_____
More than half the days	(#) _____ x 2=	_____
Nearly every day	(#) _____ x 3=	_____

Total Score: _____

Interpreting PHQ-9 Scores			**Actions Based on PH9 Score**
		Score	**Action**
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 – 14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

*PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website
www. Depression-primarycare.org/clinicians/toolkits/materials/forms/phq9

_____

Clinician Signature Date

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Client Name: _____ Client Age: _____
Date Completed: _____ Start Time: _____ Stop Time: _____

SERVICE PLAN SIGNATURE PAGE

CLIENT ACTIVE PARTICIPATION STATEMENT: I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

_____

_____

_____ _____
Member Signature, **12 or older** Date Parent/Guardian Signature Date

***Adult members: Has the Treatment Plan Advocate form been completed and signed?** ☐**Yes** ☐**No**
Has the Advanced Directive/Living Will form been completed and signed? ☐**Yes** ☐**No**
(Attach to signature page and submit together – required by OHCA and ODMHSAS)

If unable to legibly sign, document reason: _____

_____
Responsible LBHP Signature, Degree/License/Under Supervision Date

_____
Agency Supervising LBHP Signature & Credentials Date

TREATMENT TEAM:

Service Type	Treatment Methodology	Frequency of Service(Week/Month)	Provider Name & Credentials
Individual Therapy	_____	_____	_____
Group Therapy	_____	_____	_____
Family Therapy	_____	_____	_____
Rehab-Individual	_____	_____	_____
Case Management	refer, link, monitor, advocate, follow-up	up to 12 units/mo	_____
Telehealth	_____	_____	_____
Other	_____	_____	_____

For Office Use Only:
Logged: _____ Treatment Team Verified: _____

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Client Name: _____ Insurance ID #: _____

Treatment Advocate Form

All adult clients receiving mental health and/or substance abuse services have the right to name a family member or other individual as a Treatment Advocate. Each consumer has the right to determine the level of involvement and decision given to the Treatment Advocate, and there will be no limitation preventing communication or collaboration between the client and their Treatment Advocate. The consumer may revoke this designation at any time, and for any reason.

Would you like to name a Treatment Advocate? ☐ **Yes** ☐ **No** **(Must select one)**

Please provide the following information to establish your Treatment Advocate:
Name: _____
Address: _____
Phone Number: _____
E-mail Address: _____

Please initial the level of involvement you would like to establish for your Treatment Advocate"
☐ **Attend intake/assessment sessions**
☐ **Assist with treatment planning**
☐ **Receive written copies of the treatment plan**
☐ **Attend therapy sessions**
☐ **Access to Medical Records**
☐ **Other:** _____
_____
_____

_____ _____
Client Signature Date

*Treatment Advocate:
I, _____ agree to serve as the Treatment Advocate for the above named client. I agree to comply with all confidentiality obligations and will only serve in the capacity stated above by the client.

_____ _____
Treatment Advocate Signature Date

Advance Directive for Health Care

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

(1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

____ See my more specific instructions in paragraph (4) below.

(4) OTHER. Here you may:

(a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,
(b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or
(c) do both of these:

_____

_____

_____

_____

_____
Initial

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of _____, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

____ transplantation

____ therapy

____ advancement of medical science, research, or education

____ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the "yes" line below, I specifically donate:

___ My entire body

Or

___ The following body organs or parts

___ Lungs	___ Liver
___ Pancreas	___ Heart
___ Kidneys	___ Brain
___ Skin	___ Bones/Marrow
___ Blood/Fluids	___ Tissue
___ Arteries	___ Eyes/Cornea/Lens

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
e. This advance directive shall be in effect until it is revoked.
f. I understand that I may revoke this advance directive at any time.
g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this ____ day of _____, 20 ____.

_____
(Signature)

_____
City of

_____
County, Oklahoma

_____
Date of birth (Optional for identification purposes)

This advance directive was signed in my presence.

_____
Witness

_____, Oklahoma
Residence

_____
Witness

_____, Oklahoma
Residence

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INTAKE/ASSESSMENT SCREENING – (Adult) – BLACK INK ONLY

All areas MUST be completed – *use None Reported if Not Applicable.*

Date: _____ Start Time:_____ Stop Time: _____

Client Legal Name: Last: _____ First: _____MI: ____ Maiden: _____

Preferred Name (if different from above): _____

DOB: _____ Age: _____ Legal Gender: (required for insurance) ☐Female ☐Male

Gender Identity: _____ Sexuality: _____ Preferred Pronouns:_____

Address: (city,St,zip) _____ County: _____

Phone #: (Primary) _____ Other: _____

Marital Status:

☐single ☐married ☐divorced ☐civil union/domestic partnership ☐widowed ☐Other: _____

Immediate/Urgent Needs: (including medical)

_____

Provider of Screening and Assessment Information: ☐Self ☐Parent/Guardian ☐Other: _____

Are you currently homeless: ☐Yes ☐None Reported If yes, for how long: _____

Race (check all that apply): ☐Alaska Native ☐American Indian ☐Asian ☐Black or African American

☐Pacific Islander ☐White/Caucasian Ethnicity: ☐Hispanic/Latino

Employment: ☐Full time ☐Part time ☐Unemployed ☐Not in work force ☐Student

Preferred Language: _____ Other Languages Spoken: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone #: _____ Address: (city,St,zip) _____

Type of treatment services needed/requested: *eligibility required

☐Individual ☐ Family ☐ Psychosocial Rehabilitation* ☐Case Management*

***Not all consumers qualify for these services**

Frequency of Services Desired: ☐Once weekly ☐Twice weekly ☐Other

Are there any referrals to and/or collaboration with another agency? ☐Yes ☐ None Reported

If yes, list name and telephone number: _____

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CDC Info: (Basic CDC Tab)

Annual Household Income: _____ Number of Dependents: _____

Inpatient History: ☐ None Reported

In the past 90 days, how many days was the consumer in restrictive placement? (00-90) _____

In the last 90 days, on how many days did an incident of self-harm occur? (00-90) _____

Do you currently have a VPO in place for any reason? ☐ Yes ☐ None Reported

If yes, is it an emergency VPO? Please provide a copy to the office for our records and your safety.

Additional Details: _____

I. BEHAVIORAL: INCLUDING MENTAL HEALTH AND ADDICTIVE DISORDERS

(a) Presenting Problem(s) – including symptomology:

_____

_____

Do you have a history of violent behavior? ☐ Yes ☐ None Reported If yes, describe and include dates:

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ None Reported If yes, describe and include dates:

_____

_____

Do you currently have thoughts of hurting yourself or others? ☐ Yes ☐ None Reported
If yes, do you have a plan? ☐ Yes ☐ None Reported ☐ N/A
If yes, what is it?

_____

_____

Any risk-taking behaviors? ☐ Yes ☐ None Reported If yes, please describe:

_____

_____

II. Emotional, including issues related to past or current trauma and domestic violence:

Have you ever been a victim of or witnessed emotional abuse and/or neglect? ☐ Yes ☐ None Reported
If yes, describe:

_____

_____

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Have you ever been a victim of or witnessed domestic violence and/or other physical abuse?

☐ **Yes** ☐ **None Reported** If yes, describe:

_____

_____

Have you ever been a victim of or witnessed sexual assault /abuse? ☐ **Yes** ☐ **None Reported**

If yes, describe:

_____

_____

History of Additional Trauma:

_____

_____

(b) Previous Treatment History:

Previous Treatment History and/or Diagnostic History (Include diagnoses, treatment information and dates):

Mental Health:

_____

_____

Substance Abuse:

_____

_____

Domestic Violence:

_____

_____

SUBSTANCE USE ☐ Not Applicable Reason: _____

Do you smoke? ☐ **Yes** ☐ **None Reported** **If so, how much? Do you have a desire quit?** ☐ **Yes** ☐ **None Reported**

Substance	First Use	Last Use	How Often	How Much	Method

Consequences of use:

☐ Problems in your life ☐ Problems in your job/school ☐ Problems in your relationships

☐ Problems with your health

☐ Convulsions ☐ Blackouts ☐ Hallucinations ☐ Shakes ☐ Nausea ☐ Overdose ☐ DT's

☐ Memory problems ☐ Legal Problems ☐ Other:

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(**C) Current and Past Psychotropic and Addiction Medications:**

Current Medications:

Are you currently taking prescribed or over-the-counter ***psychotropic or addiction*** medication?

☐ Yes ☐ None Reported

If yes, list medications below:

Medication	Dosage/Frequency	Date Initiated

How have you adjusted to treatment/medication?

_____

Past Medications:

Medication	Dosage/Frequency

(D) Family history of mental health and other addictive disorders.

Any history of alcohol/drug abuse or mental illness in family of origin? ☐ Yes ☐ None Reported

If yes, list family member(s): _____

Does significant other drink, smoke, use prescription drugs or use any other mood-altering substances?

☐ Yes ☐ None Reported ☐ N/A If yes, please describe:

_____

III. Physical/medical including medications:

(a) HEALTH HISTORY/CURRENT BIOMEDICAL CONDITIONS

Any current medical/health/dental problems? ☐ Yes ☐ None Reported

If yes—what is the diagnosis/problem(s)?

_____

_____

If applicable - What treatments are you receiving?

_____

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Do you have an advanced directive? ☐ Yes ☐ None Reported
If so, how will it impact your treatment?

_____

Any disabilities that would affect your treatment? ☐ Yes ☐ None Reported
If yes, please describe: _____
Any allergies to medication? ☐ Yes ☐ None Reported If yes, List

_____

(b) current and past physical health medications:

For consumers 14 years and up
*Do you desire assistance in accessing birth control/family planning, or other resources?
☐Yes ☐None Reported
List resources requested: _____

For consumers of all ages:

Are you currently receiving hormone therapy? ☐ *Yes (list below)* ☐ *None Reported*
If yes, do you feel supported by your family/friends? _____

Current Medications:
Are you currently taking prescribed or over-the-counter ***physical health*** medication?
☐ Yes ☐ None Reported
If yes, list medications below:

Medication	Dosage/Frequency	Date Initiated

How have you adjusted to treatment/medication?

_____

Past Medications:

Medication	Dosage/Frequency

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IV. SOCIAL AND RECREATIONAL

(a) family and other relationships:

FAMILY/MARITAL, SOCIAL HISTORY, LIVING SITUATION

With whom do you currently live?

_____

Who have you lived with in the past?

_____

Any significant childhood losses? Include divorce, death, and estrangement. (include ages)

_____

_____

(b) recovery and community support:

To whom do you currently look for support?

_____

Do they support your entering treatment? ☐ Yes ☐ None Reported

_____

Are you experiencing severe isolation or withdrawal from social contact? ☐ Yes ☐ None Reported

If yes, explain:

_____

Do you feel supported by your family in regards to your identity? ☐ Yes ☐ None Reported

(c) leisure and wellness activities:

What do you currently like to do for recreation?

_____

How have you spent your leisure time in the past?

_____

(d) culture, including traditions and values.

Cultural Attitude/Orientation: (Values/Beliefs/Culture of Violence/Culture of Sexual abuse/Ethnic Culture/Religious Culture). ***Cannot be NONE REPORTED***

_____

_____

How could your cultural orientation/practices affect treatment?

_____

_____

What is your religious background? ☐ _____

What are some of your favorite traditions?

_____

_____

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V. Vocational

(a) educational attainment, difficulties, and history:

EDUCATIONAL HISTORY ☐ **Not Applicable Reason: _____**

Last year completed & Name of school:_____

Which grades, if any, did you repeat? _____

What vocational school or college have you attended?_____

List specialized training, if any _____

Do you have a desire to go to college/higher education? _____

Would you like help with pursuing higher education resources? ☐ Yes ☐ No

(b)current or previous military service including discharge status:

MILITARY HISTORY (clients 16 years +) ☐ **Not Applicable Reason: _____**

Have you ever been in the military? ☐ Yes ☐ No

If yes, what branch, dates of service, and type of discharge? _____

Did you have combat experience? ☐ Yes ☐ No

Are you currently experiencing any of the following symptoms? ☐Nightmares/flashbacks

☐ outbursts of anger ☐feelings of sadness or guilt ☐ intrusive memories or thoughts

(c) current and desired employment status.

OCCUPATIONAL HISTORY (clients 16 years +) ☐ **Not Applicable Reason: _____**

Employer/Job Title: _____ How long employed? _____

Other sources of income (i.e. SSI, disability, VA, retirement, child support, etc.): _____

What kinds of work are you qualified to perform? _____

CLIENT'S QUALITIES (client responses needed)

What are your strengths/abilities? (assets, resources, natural positives)

_____

What are your needs/liabilities? (weaknesses, what do you need to recover)

_____

What are your abilities/interests? (skills, aptitudes, capabilities talents, competencies)

_____

What are your preferences? (what will enhance treatment experience?)

_____

What do you expect from this program in terms of service?

_____

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Therapist's expectations:

_____

_____

_____

Diagnosis -ICD 10 DIAGNOSIS - WRITE OUT ENTIRE DIAGNOSIS – DO NOT ABBREVIATE

(If using DC: 0-3, use the appropriate crosswalk and enter the appropriate ICD-10 diagnosis code and diagnosis)

PRIMARY CODE:_____ DISORDER: _____

SECONDARY CODE:_____ DISORDER: _____

TERTIARY CODE:_____ DISORDER: _____

Psychosocial Interpretive Summary:

(Therapist summary of biopsychosocial information – this is NOT the same as the interpretive summary for the treatment plan)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Therapist Signature/Credentials **Date**

_____ _____

Client Signature **Date**