ABLE Clinical Services Inc.
Achieving Balanced Life Effects

For Office Use Only:

Patient ID: _____
Admit Date: _____
Diagnosis: _____

ABLE Clinical Services, Inc.

Counseling Consent Form for a Minor Child
(14 years old and over)

In general, counseling is a short-term arrangement and is focused on problem-solving. It is usually recommended for a client to improve a specific behavior, effective communication skills, conflict resolution, interpersonal relationships, decision making skills, anger management, or other issues that are impacting a client's success in a variety of situations in their life.

Reason for seeking services: _____

Where did you learn about ABLE Clinical Services, Inc. for assessment and counseling?

☐ School staff member *Who referred you?* _____
☐ Insurance Company Referral *Who referred you?* _____
☐ Physician Referral *Who referred you?* _____
☐ Friend/Family Referral *Who referred you?* _____
☐Self-Referred ☐ Other: _____

Patient Information

Name: _____ **Gender:** _____ **Age:** ____ **Date of Birth:** _____ **SSN:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

How long at this address? _____ **email address:** _____ **Phone Number:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Patient Ethnicity: ☐Caucasian ☐Native American (Tribal Affiliation) _____ ☐African American ☐Hispanic ☐Asian ☐Indian ☐Pacific Islander ☐Other_____

Patient Language Preference: ☐English ☐Navajo ☐Spanish ☐Other _____

Preferred Way to Receive Information: ☐Verbally ☐In Writing ☐Both verbally and in writing

Patient's Current Education Enrollment: ☐Public School ☐Private School ☐Homeschool ☐Not enrolled in any school
☐Full-Time Student Name of School(s): _____
☐Part-Time Student Name of School(s): _____

Patient Education History: What is the highest education level the patient has successfully completed?

☐Jr.High / Middle School ☐7th Grade ☐8th Grade ☐9th Grade
☐High School ☐9th Grade ☐10th Grade ☐11th Grade ☐12th Grade
☐Some College (Including Dual-Credit Classes) **Does your child like school?** ☐Yes ☐No

Is the patient currently employed? ☐ No ☐ Yes If yes, complete the following:

Current Employer: _____ **Patient's Job Title:** _____

Spiritual / Religious Beliefs

Is patient an active member of a church or religious organization? ☐ No ☐ Yes

If yes: which church or organization to they identify or belong? ☐ Agnostic ☐ Catholic ☐ Christian ☐ Baptist ☐ Jehovah's Witness ☐ Jewish ☐ Mormon(LDS) ☐ Methodist ☐ Presbyterian ☐ Protestant ☐ Spiritual/Not Religious ☐ Atheist ☐ No Religious Beliefs ☐ Other: _____

Family Dynamics

Who has legal custody of the patient? _____ **Relationship to client:** _____
With whom does the patient currently reside? ☐ Both biological parents in same household ☐ One biological parent: _____
☐ Biological mother and step-parent ☐ Biological father and step-parent ☐ Grandparents ☐ Other relative: _____
☐ Foster Care ☐ Other: _____

Parents Marital Status: ☐ Single (*Never Married*) ☐ Married: *How Long?* _____ ☐ Divorced: *How Long?* _____
☐ Partnered: *How Long?* _____ ☐ Widowed: *How Long?* ____ *(Deceased Parent)*_____

Number of Siblings in the Home: Total: _____ Older Brothers: _____ Older Sisters: _____
Younger Brothers: _____ Younger Sisters: _____

Relation to Siblings:

Biological (same mother and father): Total: _____	Brothers: _____	Sisters: _____
Half-Biological (same mother; different father): Total: _____	Brothers: _____	Sisters: _____
Half-Biological (same father; different mother): Total: _____	Brothers: _____	Sisters: _____
Adopted / Step-siblings: Total: _____	Step-Brothers: _____	Step-Sisters: _____

History

Mental Health: Check any/all of the following that patient has previously been diagnosed with and/or treated for:
☐ Depression ☐ Anxiety ☐ PTSD *(Summary of Trauma Experience:)* _____
☐ Bi-Polar Disorder ☐ Dementia: *(circle)* Alzheimer's or Vascular ☐ Eating Disorder _____ ☐ Personality Disorder
☐ Self-Harm (describe)_____ □ Suicidal Ideation ☐Previous Suicide Attempt(s)
☐ Other: _____

What medications (including supplements) are you currently taking?

Medication Name	Dosage	Frequency	What is this intended to treat?

Substance Use History:

Alcohol Consumption: ☐Never ☐Former ☐Current Age when first started: ___ # per day: _____ Type: _____
Tobacco Use: ☐Never ☐Former ☐Current Age when first started: ___ # per day: _____ Type: _____
Marijuana Use: ☐Never ☐Former ☐Current Age when first started: ___ # per day: _____ Type: _____
Recreational Drug Use: ☐Never ☐Former ☐Current Age when first started: ___ # per day: _____ Type: _____

Please read and initial each of the following sections to indicate that you have read and understand each portion.

_____
Parent Initials

Notice of Privacy Practices: A printed copy of the Notice of Privacy Practices has been offered to me, and available for me to keep for my records.

_____
Parent Initials

Confidentiality is a key feature of the counseling experience. The information discussed during the counseling meetings will not be shared with anyone without the client's permission, except in situations required by law. These situations are described below:

- In the case that the professional determines that a client in in danger of harming him/herself or of harming others, ABLE Clinical Services, Inc. is required to take action to prevent imminent danger. Every effort will be made to work with you and to inform you in such a case.
- If instances of previously unreported sexual or physical abuse of a minor or elder are brought to light, New Mexico state law requires the staff at ABLE Clinical Services, Inc. to report this information to the proper authorities or assist you in making such a report.
- If counseling records are subpoenaed by a Court of Law, the staff at ABLE Clinical Services, Inc. will attempt to contact you before releasing any records. However, we do have to comply with the court.

_____
Parent Initials

Informed Consent and Provision of Services: ABLE Clinical Services, Inc. is required to provide a psychological diagnosis and a treatment plan to address the specific needs of every client. Treatment plans may include individual, group, or family counseling. Counseling services may be provided in person, or via teletherapy. Teletherapy services are conducted with interactive audio and video connection in real time to create an in-person experience similar to that achieved in a traditional encounter.

_____
Parent Initials

Informed Consent Regarding Payment for Services: Arrangement for payment of services must be made prior to the services being provided.

- If ABLE Clinical Services, Inc. is an actively enrolled provider with your Insurance Company, you must provide all information needed to bill the company direct on your behalf. Any co-pay or deductible amount that is required to be paid by you must be paid at the time that you check-in for your scheduled service appointment.
- If ABLE Clinical Services, Inc. is NOT an actively enrolled provider with your Insurance Company, we will not bill your insurance company on your behalf. The self-pay fee amount must be paid by you at the time that you check-in for your scheduled service appointment. A detailed receipt can be provided to you that will allow you to submit a claim to your insurance company for reimbursement.
- Any insurance company that you intend to have involved with payment for services, (including reimbursement for direct-payment for services) will require the diagnosis and treatment plan to be disclosed to the insurance company.
  - ☐ Yes, I will be using insurance to pay for services provided by ABLE Clinical Services, Inc. and I give permission for diagnosis and treatment plan information to be disclosed, as needed, to ensure insurance company payment for services.
    - Name of Insurance Company: _____
    - A Copy of your Insurance Card must be provided to allow for communication with the insurance company on your behalf.
  - ☐ No, I will not be using insurance to pay for services provided by ABLE Clinical Services, Inc. and do not give permission for diagnosis or treatment plan information to be disclosed.

_____
Parent Initials

☐ **No-Show or Same-Day Appointment Cancellation Policy:** Patients will receive electronic notices and reminders of scheduled appointments. Patients will be asked to confirm their appointment to ensure that their scheduled time is held for them. Failure to confirm the appointment may result in service times being cancelled for you and given to other clients. Appointments must be rescheduled or cancelled at least 24 hours in advance to avoid a fee being charged to you for appointments that could otherwise be offered to other clients. This fee will be equal to 50% of the customarily billed amount for the appointment scheduled. Your insurance company will not be responsible for paying this fee.

_____
Parent Initials

Communication or Collaboration with other providers: Please check one of the following options regarding communication with other medical and/or behavioral health providers you may be working with.

- ☐ **Yes**, I am currently receiving care from another medical or behavioral health provider:
  - ☐ I give permission for ABLE Clinical Services, Inc. to communicate with the following medical and/or behavioral health provider to coordinate services and share pertinent information.
    - Provider Name: _____ Phone: _____
  - ☐ I do not give permission for ABLE Clinical Services, Inc. to communicate with another medical and/or behavioral health provider to coordinate services and share pertinent information.
- ☐ **No**, I am not currently receiving care from any other medical and/or behavioral health provider.

_____
Parent Initials

Informed Consent Regarding Public Health Order Compliance: ABLE Clinical Services, Inc. is required to comply with any and all public health orders issued by the Department of Health and Human Services for the State of New Mexico. In exchange for being permitted to enter the premises of ABLE Clinical Services, Inc. (the "Business"), to access, or participate in, mental health services (the "Activity"), I agree to the following as described below:

- **Patient agrees to instructions and requirements:** I will follow all of the instructions of the Business while on the Premises, including: business guidelines and requirements.
  - I agree not to enter, or have other persons accompany me inside the Premises, if I am, or they are, experiencing symptoms of COVID-19 such as cough, shortness of breath, or fever, have a confirmed or suspected case of COVID-19, or have come in contact in the last 14 days with a person who has been confirmed or suspected of having COVID-19.
- **Patient assumes the risk:** I am aware of the highly contagious nature of COVID-19 and the risk that I, or my companions, may be exposed to or contract COVID-19 by being on the Premises and engaging in the Activity.
  - I acknowledge that I am voluntarily entering the Premises to engage in the Activity with knowledge of the danger involved. I hereby agree to accept and assume all risks of personal injury, illness, disability, or death related to COVID-19, arising from my being on the Premises or engaging in the Activity, whether caused by negligence of the Business or otherwise.
- **Patient releases Provider from liability:** I hereby expressly waive and release any and all claims, now known or hereafter known, against the Business and its owners, employees, affiliates, and officers, on account of injury, illness, disability, or death arising out of or attributable to my being on the Premises or engaging in the Activity and being exposed to or contracting COVID-19, whether arising out of the negligence of the Business, its owners, employees, affiliates, officers, or otherwise.

I have read this document, and I understand the contents of this document. By signing here, I am giving informed consent for my child to enter into a provider/patient relationship with ABLE Clinical Services, Inc. and its staff members. I understand the rights and responsibilities that I have as the Parent/Guardian of this client.

Parent/Guardian Signature: _____ Date: _____

Patient Signature: _____ Date: _____