



ABLE Clinical Services, Inc.

Counseling Consent Form for Adults

For Office Use Only:

Patient ID: _____

Admit Date: _____

Diagnosis: _____

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: _____

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 _____

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

Jr.High / Middle School: 6th Grade 7th Grade 8th Grade

High School: 9th Grade 10th Grade 11th Grade 12th Grade Do you have: High School Diploma GED

College/Trade School: Technical School Military Some College Associates Degree Bachelor's Degree
 Master's Degree Doctoral Degree

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

Patient's Current Employment Status: Full-Time Part-Time Unemployed Self-Employed Homemaker/Caregiver

Disabled: Date _____ Retired: Date _____ Length of Current Employment Status: _____

Current Employer: _____ Patient's Primary Occupation: _____

Family Dynamics

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

Number of Siblings: 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: _____

Your Marital Status: Single (Never Married) Divorced: How Long? _____ Married: How Long? _____ (Spouse): _____
 Partnered: How Long? _____ (Partner): _____ Widowed: How Long? _____ (Spouse): _____

Children: Biological children: Total: _____ Sons: _____ Daughters: _____
Step-children: Total: _____ Step-Sons: _____ Step-Daughters: _____

Grandchildren: Total: _____ Grandsons: _____ Granddaughters: _____

Spiritual / Religious Beliefs

Does the patient have a specific spiritual or religious beliefs or practices? No Yes

If yes: 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 Traditional Native American

Other: _____

Military Service

Has patient been a member of the military: No Yes If Yes: Yrs. of Service _____ Discharge Type: _____

What is patient's perception of their service experience? Positive Negative Neutral

Branch: Army Navy Air Force Marines Coast Guard National Guard

Era of Service: WWII Korea Vietnam Desert Storm/Shield Peace Time

Is Patient a Combat Veteran? No Yes

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: _____

Has patient participated in Mental Health Therapy/Counseling services before: No Yes

If Yes: check all that apply: In-Patient Outpatient Individual Family Group

What is patient's perception of their service experience? Positive Negative Neutral

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: _____

Misuse of Prescriptions: Never Former Current Age when first started: ___ # per day: ___ Type: _____

Other Information

Resources: Check any/all of the following that patient has access to, or feels secure about:

Adequate Housing Adequate Transportation Adequate Education Adequate Health Mental Health Resources

Supportive Family/Friends Reliable Support Network Access to Healthcare Stable Family Connection Willing to Learn

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

Client
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.

Client
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 is 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.

Client
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.

Client
Initial

Communication or Collaboration with other Individuals: Please check one of the following options regarding communication with other individuals regarding your care or progress.

- I give permission for ABLE Clinical Services, Inc. to communicate with the following individual to coordinate services and share pertinent information.
 - Name: _____ Phone: _____ Relationship: _____
- I do not give permission for ABLE Clinical Services, Inc. to communicate with any other individual to coordinate services and share pertinent information.

Client
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.

Client
Initial

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.

Client
Initial

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.

Client
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 entering 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 client.

Client Signature: _____

Date: _____

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

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