Adult Client Information

Client's Name (First MI Last):

Preferred Name or Nickname:

Date of Birth:	Age:	Gender:

Marital Status: ☐ Single ☐ Married ☐ Other:

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other:

Mailing Address:

Physical Address:

Please DO NOT list any numbers where you would prefer not to receive calls or messages.

Home Phone:	Cell Phone:	Work Phone:

Email: *Check this box to receive email communication from Counseling Associates* ☐

As a courtesy, we offer the option of appointment reminders by email, text, or landline phone message.
These messages are delivered 48-hours in advance. These serve as reminders only and should not be relied upon exclusively.
Please also be sure to note your appointment in your own personal calendar.

Would you like to receive optional courtesy reminders? ☐ Yes ☐ No

Requested Method: ☐ Email ☐ Text ☐ Landline Phone Message *(select one only)*

Financial Information

I understand that I am responsible for charges incurred that are not covered by my insurance and that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I authorize the release of information necessary to file a claim with my insurance company, including electronically, and assign benefits of Counseling Associates of New London, PLLC, Counseling Associates of Newport, Counseling Associates of Claremont, and Counseling Associates of the Upper Valley. A copy of this signature is as valid as the original.
We have a standard 24-hour cancellation policy. Please notify your therapist as soon as you know you will be unable to keep an appointment ***at least*** *24 hours, preferably 48 hours, in advance of the scheduled time. The policy of this office is to charge $60 for those missed sessions not canceled with 24 hours notice.* ***Insurance companies will not pay for sessions that you miss, and it would be fraudulent for us to submit a claim for missed sessions.***

Signature: Date:

Primary Insurance Company:	Secondary Insurance Company:
ID#: Group #:	ID#: Group #:

Please provide your insurance card(s) for copying at the time of appointment or upload via our secure form on ca-mh.com.

Responsible party to whom statements will be sent if different from Client:

Name:	Relationship:
Address:	Phone #:

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

☐ I authorize coordination of care between my PCP and Counseling Associates.
Please sign release on following page.

☐ I decline coordination of care at this time. *Do not complete release on following page.*

☐ I have questions about coordination of care and would like to wait and speak with my therapist.

☐ I have other providers or individuals for whom I would like to authorize communlcations.
Please sign release on following page and access additional forms at (website)

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- Notification of Privacy Policies Regarding Protected Health Information (PHI)
- Telebehavorial Health Informed Consent
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering. I have had all of my questions answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my therapist's control. (e.g. if my treatment has been court-ordered, I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, and the Upper Valley. I consent to receive services from Counseling Associates and I agree to take an active role in my treatment.

Signature of Client Date

Printed name

Authorization to Disclose Health Information

I, _____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, Newport, Claremont, & Upper Valley** to

☐ Release ☐ Receive ☐ Exchange

Protected Health Information (PHI) about the above referenced individual to:

Name:	Phone:
Address:	

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

☐ Mental Health (MH) ☐ Substance Use Disorder (SUD) ☐ Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check ☐**Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to: assessment, treatment plans, progress notes, medication, attendance, test results, behavioral support plans, discharge reports, etc.*

Check ☐**No** if you wish to specify which of the items below to disclose:

☐Yes	☐No	Attendance
☐Yes	☐No	Assessments/Evaluations including diagnosis, treatment recommendations
☐Yes	☐No	Treatment Plan/Individual Plan of Care
☐Yes	☐No	Progress Notes
☐Yes	☐No	Medications Prescribed
☐Yes	☐No	Agency Discharge Summary/Plan
☐Yes	☐No	Behavioral Support Plans
☐Yes	☐No	Test Results (includes lab results and urine toxicology reports)
☐Yes	☐No	HIV/AIDS
☐Yes	☐No	Other (must specify):

Date range of information to be disclosed:

The purpose of the disclosure:

Date or event upon which this authorization will expire:

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

• I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be discloed without my written consent, unless otherwise allowed by the regulations or required by law.

• I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.

• For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.

• I understand that confidentiality of such records is also protected by State law.

• I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.

• I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.

• I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.

• I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.

• I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print) _____ Date _____

Signature of Client _____ Date _____

Verbal revocation received:_____(date) at _____(time)
Staff Member:

Written revocation: I hereby revoke this authorization on _____(date).
Do not release any further information under this authorization.
Client Signature:

Electronic revocation received:_____(date) at _____(time)
Staff Member:

Health Information

Primary Care Provider:	Date of Last Physical:
Other Providers:	
Current Health: ☐ Good ☐ Fair ☐ Poor	Are you concerned about your health? ☐Yes ☐No
Allergies:	☐ No Known Drug Allergies

Current Medications

Medication	Dosage	Medication	Dosage

Please attach additional sheet(s) as needed for additional medication information.

Substance Use

How often do you have drinks containing alcohol?

☐ 4+x/week ☐ 2-3x/week ☐ 2-4x/month ☐monthly or less ☐ never

How many drinks containing alcohol do you have in a typical day?

Do you use tobacco?	How much?
Other substances used:	Frequency:

Are you concerned about your ☐ alcohol, ☐ tobacco, or ☐ other substance use?

Physical Health Issues:

Mental Health or Substance Use Treatment History, including hospitalizations:

History of self-harm? ☐ Yes or ☐ No

History of trauma, abuse, or violence? ☐ Yes or ☐ No

Please Tell Us

In a sentence or two, please describe the reason for the appointment:

What do you hope to gain from therapy?

What strengths do you have that you will bring to this work?

Have you seen a therapist before? ☐ Yes ☐ No
If Yes, please note the name of the therapist(s) and approximate date(s):

counseling associates

Substance Use (Continued)

Directions: *The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you.*

During the last 6 months...	Yes	No
Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, marijauna, cocaine, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)	☐	☐
Have you felt that you use too much alcohol or other drugs?	☐	☐
Have you tried to cut down or quit drinking or using alcohol or other drugs?	☐	☐
Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, counselors, or a treatment program)	☐	☐
Have you had any health problems? *For example, have you:* ☐ Had blackouts or other periods of memory loss ☐ Injured your head after drinking or using drugs ☐ Had convulsions, delirium tremens ("DTs")? ☐ Had hepatitis or other liver problems? ☐ Felt sick, shaky, or depressed when you stopped? ☐ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs? ☐ Been injured after drinking or using? ☐ Use needles to shoot drugs?	☐	☐
Has drinking or other drug use caused problems between you and your family or friends?	☐	☐
Has your drinking or other drug use caused problems at school or at work?	☐	☐
Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	☐	☐
Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	☐	☐
Are you needing to drink or use drugs more and more to get the effect you want?	☐	☐
Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	☐	☐
When drinking or using drugs, are you more likely to do something you wouldn't normally do? (Such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone)	☐	☐
Do you feel bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drinking or other drug problem?	☐	☐
The next questions are about your lifetime experiences:	Yes	No
Have any of your family members ever had a drinking or drug problem?	☐	☐
Do you feel that you have a drinking or drug problem now?	☐	☐

counseling associates

Patient Health Questionnaire

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
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	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Total Score: 0

General Anxiety Disorder Screening

Over the *last 2 weeks*, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid, as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Column Totals:	0	+ 0	+ 0	+ 0

Total Score: 0

SUBMIT