ADDRESS: 412 SIPAPU TAOS, NM 87571
PHONE: 575-770-9513
http://goldenwillowcounseling.com

Client Information Sheet ***All information in this packet is kept strictly confidential***

Name______________________________________Age_______Sex_______Date_________________

Birthdate______________Social Security Number___________________Marital Status______________

Mailing Address____

Parent/Guardian (if applicable) ____

Physical Address____

Employer name and address____

Home Phone____________Work Phone____________Cell Phone / Pager_________________________

Email Address ____

Occupation_____________________Driver's License No. and State______________________________

Names, ages of spouse and/or children (Siblings, if patient is a child)______________________________

____

Whom do you wish I contact in case of emergency (give names and numbers)?______________________

____

Primary care physician: _____________________ Who referred you to me?________________________

Do you have any medication allergies? If so list them. ____

Are you currently taking any medications? If so list them. ______________________________________

Have I treated any members of your family or close friends? _____________________________________

Primary Insurance Co.______________________________________Policy No.___________________
Group No.____________________ Subscriber's name____

Secondary Insurance Co.____________________________________Policy No.___________________
Group No.____________________ Subscriber's name____

Medicaid Carrier and No.________________________________

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FIRST APPOINTMENT POLICY

I understand that my first appointment with Golden Willow Counseling (GWCS) does not automatically confer a commitment on my part or on the part of Golden Willow Counseling for on-going treatment. The first appointment is rather a session for me to decide if I wish to continue treatment with Golden Willow Counseling. It is also a session for Golden Willow Counseling to better evaluate the conditions for which I am seeking treatment and to decide if on-going treatment would be best undertaken at GWCS. Some parties, to benefit their treatment, require services which are better provided by another community mental health center.

______________________________________ ____________________

(signature) (date)

MISSED APPOINTMENT POLICY

If I have to cancel an appointment, I agree to do so by contacting Golden Willow Counseling at least 24-hours in advance. I may cancel by text/phone call or email at:

____

If I am a fee for service client, I agree to pay $60 for any missed appointments that I have not cancelled 24 hours in advance. If I am a MEDICARE or Medicaid client, I understand that if I miss two appointments without canceling 24 hours in advance, that Golden Willow Counseling can no longer continue to provide me services. I understand that these stipulations are valid whether or not I have received a reminder phone call for an appointment.

______________________________________ ____________________

(signature) (date)

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CLIENT RIGHTS & GRIEVANCES PROCEDURES

1. The client has the right to be treated with dignity and respect guaranteed to all citizens.

2. The client has the right to refuse services and to be informed of any consequences of his/her action.

3. The client has the right to privacy.

4. The client has the right that all information be treated as confidential. There are some exceptions to confidentiality including but not limited to: Danger to self or others, suspected child abuse or neglect, consent to release records, legal guardian access to records, and/or Court order.

5. The client has the right to give informed consent prior to starting any services.

6. The client has the right to have an explanation of the program in which they are being enrolled. This includes an orientation to basic expectations, hours when services are available, cost of service and terms of discontinuation of services.

7. The client has the right to be advised if the clinician proposes to engage in any research projects affecting his/her care. The client has the right to refuse to participate in such research projects.

8. The client has the right to file a grievance. Services shall continue as planned during grievance process.

9. The client has the right to access their records in accordance with acceptable mental health practices.

10. The client has the right to insert a statement into their records regarding needs or concerns regarding service.

11. The client has the right to have any incident reported to the proper authorities, reviewed, and acted upon if necessary.

12. The client has the right to receive adequate and appropriate medical care.

13. The client has the right to receive appropriate adult guidance and supervision.

14. The client has the right to the best therapeutic care available by Golden Willow Counseling.

15. The client has the right to advocacy related to improving social conditions and developing resources beneficial to their life.

CLIENT RIGHTS & GRIEVANCES PROCEDURES

Client Signature: ____ Date: _____________

Parent/Legal Guardian Signature: ____________________________ Date: _____________

Witness Signature: ____ Date: _____________

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Notice of Privacy Practices

Golden Willow Counseling may collect health information, including mental health and substance abuse information, for the purpose of providing quality services to you. The people providing services to you may use your information or disclose it to others. This NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect your medical information. We are also required to abide by the practices described in this notice.

Uses and Disclosures of Health Information

We will generally get your written authorization before using or disclosing your health information outside of Golden Willow Counseling. However, there are some situations, as described herein, when we do not need your written authorization before using your health information or sharing it with others.

We may share your health information with doctors, nurses, pharmacists and other treatment providers who are involved in providing health related services to you, and they may, in turn, use that information to diagnose or treat you.

We may use or disclose your health information so that we can obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after you have been treated or to obtain prior approval for services.

We may use or disclose your health information in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in serving you, or to educate our staff on how to improve the care they provide for you.

We may use your health information when we contact you with a reminder that you have an appointment for treatment or to tell you of a related service that may be of interest to you.

We may use or disclose your health information in an emergency or for an important public need.

If you do not object, we may disclose your health information to a family member, relative, or close personal friend who is involved in your treatment or payment for that treatment. We may also disclose your health information to help notify or locate a family member or other person responsible for your care.

We may use or disclose your health information if you need emergency treatment or if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities.

We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities and services.

We may disclose your health information if we are ordered to do so by a court or administrative hearing officer that is handling a legal matter or to persons authorized by court to receive the information.

We may disclose your health information to law enforcement officials for the following reasons:

- ❑ To comply with court orders or laws;
- ❑ Identifying or locating a suspect, fugitive, witness, or missing person;
- ❑ If you have been the victim of a crime;
- ❑ Your death resulted from criminal conduct;
- ❑ To report a crime that occurred on our property; or
- ❑ To report a crime discovered during an offsite investigation as required by law.

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We may use or disclose your health information when necessary to prevent a serious threat to your health or safety or to the health or safety of another person or the public.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they may deem necessary to carry out their military mission.

If you are a client of Golden Willow Counseling. Golden Willow Counseling and interagency community and/or counseling services, or you are detained by a law enforcement officer, we may disclose your health information. If necessary, to provide you with health care or to maintain safety, security and good order where you are being detained or to where you are being transferred.

We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner.

We may use or disclose your health information if we have removed any information that might reveal who you are.

We may disclose your health information to a person or company as required by the US Food and Drug Administration.

We will ask for your written authorization before using your health information or sharing it with others for any other purpose. For example, in order to participate in a research project.

Your Rights Regarding Your Health Information

You generally have the right to inspect and copy your health information. You may be charged for copying and mailing costs.

You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement.

You have the right to request that we contact you in a way that is more confidential for you, such as at work instead of at home.

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

You may request a paper copy of this notice, even if you have previously agreed to receive this notice electronically.

The Effective date on this Notice of Privacy Practices is November 11, 2016. We may change our privacy practices from time to time. We may make the changed notice effective for health information we already have. If we change the notice, we will provide you with the revised notice. **Thank you for taking the time to read this important information. After you have carefully read the Notice, please sign the attached acknowledgment and return to us.**

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NOTICE OF PRIVACY PRACTICES

Acknowledgement Form

Client Name: ____
(Last, First, Middle)

Date of Birth: ____
(Month, Day, Year)

Client Address: (No. And Street, City, Zip code)

____

____

Telephone Number: ____

I acknowledge that I was offered or provided a copy of Golden Willow Counseling Notice of Privacy Practices. I was given an opportunity to ask questions at the address or phone number listed on the Notice of Privacy Practice.

Signature of Client or Person Representative: ____

Date: __________________

If signed by Personal Representative, relationship to Client: _______________________

Please return the signed acknowledgement to Golden Willow Counseling.

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Fee Agreement

Individual, Couple or Family Psychotherapy:

$120 per session (50 minutes) –or- Sliding Scale from $120 - $60

Intern Counselors accept as low as $20

Payment for Services

Payment or insurance copayment is expected at the time of service unless other arrangements have been made. The client is responsible for payment for services if insurance does not pay.

Appointment Cancellations

Please give at least 24 hours' notice for cancellations to avoid a charge for the appointment. Late cancellation will be charged $60 (except Medicaid or Medicare clients). A message left on voice mail or text 24 hours in advance will be considered adequate notice of cancellation.

Upon careful consideration of the value of therapy and my resources to pay for it, I agree to pay ____________ for therapy with Golden Willow Counseling. I agree if my financial situation changes to renegotiate this agreement to reflect that change.

____ ____________________

Client Signature Date

____

Client Print Name

____ ____________________

Therapist Signature Date

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CONSENT FOR TREATMENT

I understand that counseling sessions with Golden Willow Counseling may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. I agree to keep Golden Willow Counseling informed of any changes in my emotional or physical well-being. **I understand if an emergency arises and I am unable to reach Golden Willow Counseling, I should go to the closest Hospital Emergency Room or contact a telephone crisis counseling hotline.**

I understand that all information disclosed within the sessions is kept confidential and is not revealed to anyone without my written permission. The only exception to this is where disclosure is required by law (e.g., when there is a reasonable suspicion of abuse of children or elderly persons, when a client presents a serious danger of violence to others, or where the client is deemed likely to harm him/herself unless protective measures are taken).

I further agree to pay all charges for services rendered at the time they are delivered. I understand that sessions not cancelled 24 hours in advance will be charged at $60. I agree to notify Golden Willow Counseling if I have a problem with payments or any other policies or treatment methods.

Golden Willow Counseling has answered all of my questions about the treatment to be provided. If I have further questions, I understand that my clinician will either answer them or find answers for me. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist.

____________________________________ ____________________

Client Signature (14 & over) Date

____

PRINT NAME

____________________________________ ____________________

Parent/Guardian Signature Date

____

PRINT NAME

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RELEASE OF INFORMATION

Client Name:____ D.O.B.________________

Address: ____
Street, City, State, Zip

A. I hereby authorize____
Name, Title

to release the following information for the purpose of coordination of treatment, care planning:

❑ Admission History and Physical
❑ Intake Information/Assessment
❑ Psychosocial Assessment
❑ JPPO Baseline Assessment
❑ Psychiatric Evaluation
❑ Chronological Offense Records
❑ Psychological Evaluation
❑ Probation/Parole Agreement
❑ Treatment Plan
❑ Court Orders
❑ Progress/Treatment Summaries

❑ School Records (report cards, discipline)
❑ Discharge Summary
❑ IEP / Ancillary Service
❑ Physical exam
❑ Educational Diagnostic Evaluation
❑ Medical Records from______________
to ____________________________
❑ PSD Referral Information/Service Plan
❑ Legal Records
❑ Placement History
❑ Consultation
❑ Other_____________________________

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The information shall be released to Golden Willow Counseling

B. I hereby authorize Golden Willow Counseling to release the above information.

To: Name:___________________________________Title____________________

Address:____

Street, City, State, Zip

PROHIBITION ON REDISCLOSURE: Federal Law and State Regulations prohibit further disclosure of this information to any person or agency without securing another proper written authorization for that purpose.

This is valid for 90 days after the date of the signature or until either party terminates in writing.

I expressly understand and agree that no legal responsibility or liability of any nature shall attach to the respondent, the agency, or its employees in acting upon this authorization and request.

____ ______________________

Signature of Client **Date**

____ ______________________

Signature of Parent/Legal Guardian (if applicable) **Date**

____ ______________________

Signature of Witness **Date**

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- ❑ Chronological Offense Records
- ❑ Psychological Evaluation
- ❑ Probation/Parole Agreement
- ❑ Treatment Plan
- ❑ Court Orders
- ❑ Progress/Treatment Summaries
- ❑ School Records (report cards, discipline)
- ❑ Discharge Summary
- ❑ IEP / Ancillary Service
- ❑ Physical exam
- ❑ Educational Diagnostic Evaluation
- ❑ Medical Records from______________ to ______________________________
- ❑ PSD Referral Information/Service Plan
- ❑ Legal Records
- ❑ Placement History
- ❑ Consultation
- ❑ Other______________________________

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____ ______________________
Signature of Client **Date**

____ ______________________
Signature of Parent/Legal Guardian (if applicable) **Date**

____ ______________________
Signature of Witness **Date**