COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

______________________________ ______________________________
First Name **Last Name**

____/____/______ _____ _______-______-_______ **Gender (*please check one*)** ☐ **Male** ☐ **Female** ☐ **Transgender**
Date of Birth **Age** **Social Security Number**

Referral Information ***(who referred you to us)***

____
Agency (if applicable) **Contact Person** **Telephone** **Fax**

____
Street **City** **State** **Zip**

____
Your Street Address **City/State/Zip** **How long at this address?**

Telephone (______)_______________________ (______)_______________________ (______)_______________________
Preferred Contact Number **Alternate Contact Number** **Alternate Contact Number**

May CCC Staff contact you at or leave a voice mail/message at this/these number(s)? ☐ **Yes** ☐ **No**

RACE:
☐ **WHITE/CAUCASIAN** ☐ **BLACK OR AFRICAN AMERICAN**
☐ **AMERICAN INDIAN /ALASKAN NATIVE** ☐ **ASIAN**
☐ **HAWAIAN / PACIFIC ISLANDER**
Ethnicity:
☐ **Mexican** ☐ **Puerto Rican** ☐ **Cuban**
☐ **Central American** ☐ **South American** ☐ **Other** _______________

______________________ ____________ ______________________
Mother's Maiden Name **First 3 letters of Mother's First Name** **Your Birth Place (*City & State)***

Are you Pregnant? ☐**Yes** ☐**No** **Have you ever used drugs intravenously?** ☐**Yes** ☐ **No**

Are you a VETERAN? ☐ **Yes** ☐ **No**

Please check the following: ☐**Single** ☐ **Married** ☐ **Domestic Partnered** ☐ **Divorced** ☐**Separated** ☐ **Widowed**

Education Completed (*Please circle years completed*) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Do you have a High School Diploma? ☐ **Yes** ☐ **No** **Are you currently employed?** ☐ **Yes** ☐ **No**

Emergency Contact ____
Name **Phone Number** **Relationship**

Do you have insurance/Medicaid? ☐ **Yes** ☐ **No** **If yes, what carrier?** ______________________

Insurance/Medicaid Member ID/Recipient Number: ______________________

How do you identify yourself? ☐ **Heterosexual** ☐ **Bisexual** ☐ **Gay/Lesbian** ☐ **Other**

(*The following question is for eligibility purposes for RW Part A, RW Part B, RW Part C, and/or HOPWA* *Only*)

HIV Status: ☐ **Positive** ☐ **Negative** ☐ **Unknown** ☐ **Never tested before**

Have you ever received services at this agency before? (*Please mark*) ☐ **Yes** ☐ **No**

If yes, when ______________________ **Who did you see?** ______________________
Therapist / Group(s)

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

CONSENT TO TREATMENT

As a client of Community Counseling Center I understand that:

1. I am entitled to treatment and rehabilitative care to include referrals to appropriate medical, psychological, and training services, as part of my treatment plan.
2. I have the right to refuse any or all parts of my treatment plan, with the exception of emergency treatment.
3. Consent to any or all parts of the treatment plan may be withdrawn at any time.
4. I will be informed of the nature, consequences, and purpose of the treatment plan, and any alternative plans and resources available.
5. All counseling sessions are confidential, but I understand that my counselor is obligated by law to inform appropriate parties if I am in danger or if I am causing danger to someone else.
6. Admission to this program does not include granting Power of Attorney to the operator or employees of the program.
7. Community Counseling Center is an approved internship site, which utilizes interns to assess, diagnose, and treat its clients under strict supervision. By signing below I hereby consent and acknowledge that an intern *may* conduct my counseling sessions at Community Counseling Center.
8. Although I may be assigned a certain number of counseling sessions at the start of my treatment, completing this number of sessions does not necessarily mean that I have successfully completed my treatment. If I have not met my treatment goals, additional sessions may be recommended by my counselor.
9. As a client of Community Counseling Center, I have read my rights and acknowledge receipt of a copy of Client Rights.
10. I understand that successful treatment is demonstrated by mental and behavioral changes sustained over time. I will have a regular opportunity to discuss with my primary therapist my progress (or lack of progress) toward meeting these goals.
11. I have been fully informed of the above, understand the process and my responsibilities as a client receiving treatment, and agree to accept such treatment and to cooperate in its implementation.

I, ____, acknowledge receiving a copy of this document.
(Please print your name here)

____________________________________ ____________________________________
Client signature Date Counselor Signature Date

____
Parent/ Legal Guardian Date

Rev 9/19/13

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

The confidentiality of alcohol and drug client records, maintained by this program (Community Counseling Center), is protected by federal law and regulations. Generally, the program, staff, volunteers, or contractual personnel may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser.

UNLESS:

- The client consents in writing.
- The disclosure is allowed by a court order, or
- The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.
- The client commits or threatens to commit a crime on program premises, or against program staff.

1. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.
2. Federal law and regulations do not protect information about a crime committed by a client, either on the premises or against any program staff, or about any threat to commit such a crime.
3. Federal law and regulations do not protect information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.
4. Federal law and regulations prohibit the re-disclosure of protected information by the discloser. **(See 42 U.S.C. 290dd-3 & 42 U.S.C. 290ee for federal laws & 42 CFR Part 2 for federal regulations)**

This consent may be revoked at any time in verbal or written form.

Client's Signature: ____Date ______________________

Authorized Representative if Client is a Minor: ____

Please print your name

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

INTAKE/CLIENT CONCERNS

The following information will assist us in recommending a treatment program that will best meet your needs. This is confidential information and will not be released without written consent. Please feel free to take your time in answering the following questions: (*Please answer the questions thoroughly. If more space is needed, please use the back of this paper).*

1. Did your referral tell you what treatment they wanted you to be involved in? If so, what treatment?

   ____

   ____

   ____

2. What are the primary concerns you wish to address in your sessions with Community Counseling Center?

   ____

   ____

   ____

   ____

3. When did these concerns begin to present as problems?

   ____

   ____

   ____

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

HIV/AIDS AND TB TESTING

Community Counseling Center is committed to provide a comprehensive treatment intervention, which includes information, prevention, and testing for HIV/AIDS and TB (Tuberculosis). Individuals accessing services at Community Counseling Center are highly encouraged to participate in this process. The services are provided by Southern Nevada Health District on a bi-monthly basis on-site at Community Counseling Center and are free of charge to clients.

BUREAU OF HEALTH REGULATIONS POLICY

Community Counseling Center does not deny or delay treatment to a prospective client on the grounds of handicap, race, gender, religious beliefs, sexual orientation, gender identity, national origin, and/or ability to pay for services. No client shall be given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or with any aid, treatment, services, or other benefits which are different, or provided in a different manner from that provided to others under the program, on the groups of handicap, race, gender, religious beliefs, sexual orientation, gender identity, national origin, and/or ability to pay for services.

IMPORTANT POLICY INFORMATION

1. Community Counseling Center highly encourages clients to be actively involved in their treatment and to become aware of the changes necessary for the success of treatment.

2. The counselor(s) will assess client's progress against treatment goals each month on whether or not clients are making necessary changes. If the counselor feels the client is not progressing the client will be informed and the client and his/her counselor will identify the changes necessary to successfully complete the program. If the client is not meeting the goals established, he/she may be recommended additional sessions until the counseling goals are met.

3. Community Counseling Center considers successful treatment as indicated by the client showing obvious, observable, cognitive (mental) and behavior (action) changes or shifts and by demonstrating the ability to maintain those changes over time. We strive to support you throughout the process.

4. Clients are expected to act in a manner that is respectful of other clients and their needs, as well as agency staff and agency property. If a client does not act accordingly, or becomes agitated or aggressive to the point that staff or clients feel threatened, Community Counseling staff may ask the client to leave the session and the premises. The agency does not engage in physical or chemical restraint, but clients refusing to leave the premised after being asked to will be removed by law enforcement officials.

5. Community Counseling Center's substance abuse program is an **abstinence-based treatment program**; therefore **abstinence** is expected while attending our treatment program.

6. Community Counseling Center is required by the State of Nevada to use a laboratory for urinalysis. The laboratory service reviews and report on specimen results collected at our agency. Counselors may request random alcohol and drug tests when clients are referred here by the criminal justice system, child protective services, and other referral sources that are involved in the client's care. If a client is asked to provide a sample for a test, the results will likely be provided within 4 to 5 days. All standard alcohol and drug tests will cost $5.00 per test. In addition, the client will be responsible for **any additional fees** associated with the test. Please note that **any positive drug test during treatment or at discharge will impact the client's treatment goals or impact whether or not the client is ready for discharge.**

Client Responsibilities (For a complete set of client responsibilities, please refer to take home package)

- Clients are expected to participate in all service decisions
- Clients are expected to pay their co-pay as has been determined by sliding fee scale established by the state of Nevada

Discharge Circumstances (The following include some criteria for dismissal of the program)

- CCC will not tolerate harassment in any form
- CCC will not tolerate abusive or threatening behavior to other clients, staff or destruction of property
- Excessive absences
- Lack of attendance or contact after 30 days under the substance abuse treatment
- Lack of attendance or contact after 90 days under any other program
- Once the fee has been determined by the sliding fee process, refusal to pay may result in **discharge** from the program per state of Nevada Division of Mental Health & Developmental Services.

Successful Completion

- Client will have completed all recommended treatment as well as achieved goals and objectives laid in treatment plan.
- Client will have paid financial balance in full or made arrangements with our financial officer.
- For mandated clients, a clean drug test is necessary to be discharged successfully.

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

MANDATED PROGRAM POLICY STATEMENT

Please read carefully: *If you are accessing services under any of our mandated program (P&P, CPS, Courts, TANF or Welfare programs = if unsure, please ask the front desk for clarification) please read the following information, print your name, date, and sign at the bottom of the page. Thank you.*

You have enrolled in the Mandated Program today by filling out all the appropriate documents and providing us financial documentation to assess your fees. This fee is for your intake session and is fee is non-refundable. During the intake session you will be assigned to the appropriate group and/or individual counseling sessions. Evaluation sessions are not counted toward your court requirement. Terms of your enrollment are as follows:

Client Responsibilities:

1. To assure that Community Counseling Center is able to make appropriate reports on my behalf, I **MUST** provide court papers and documents. It is **ESSENTIAL** that these papers include:
   a. Name, address, phone number, and fax number of the judge, agency, P.O., and/or individual that would be considered the referral source.
   b. A return to court date and case number.
2. Out of State cases that require a substantial amount of additional paperwork to be completed by the staff of Community Counseling Center will incur additional fees.
3. It is the client's responsibility to attend all sessions required. If a client arrives to treatment **10 minutes late**, he/she **will not** be allowed in group.
4. The Mandated Program Policy requires that all clients should report at least a half hour before group or individual sessions to check in and make payments. If a client cannot pay at the time of service, then he/she must meet with a financial accounts manager to possibly qualify for payment arrangements. All unpaid balances are reported to referral sources.
   a. **Please Note**: Once the fee has been determined by the sliding fee process, refusal to pay may result in discharge from the program per state of Nevada Division of Mental Health & Developmental Services.
5. This is an **abstinence-based program**, therefore if a client exhibits symptoms of intoxication before or during group or individual sessions, he/she will be asked to take a drug/alcohol test at the cost of $5.00. If a client declines such testing, the client will be notified that it counts as a positive test and the client's referring agency will be notified. Additionally, he/she will not be allowed to attend group or individual session that day.
6. CCC utilizes random testing and at any time a client may be asked to take a drug test (urinalysis). If a client takes a test or requests a drug tests, he/she must pay **any additional** fees associated with the test. The standard fee for drug tests is $5.00
7. **CCC philosophy:** Compliance is understood as attendance, participation and financial responsibility in terms of paying for services as charges are incurred. Having the ability to pay for services and failing to do so may result on discharge from the program.
8. **In ALL mandated programs,** if a client does not attend treatment in a thirty (30) day period, she/he will be discharged from the program. If a client seeks re-entry into a program after discharge, then the client will be charged an additional $25.00 processing fee. All clients must attend an exit interview.

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

FEE DETERMINATION POLICY AND FINANCIAL INFORMATION

The following information is protected under the confidentiality regulations of the Substance Abuse Prevention and Treatment Agency and will not be provided to anyone outside this agency.

As a client of a treatment program receiving funds administered by the Substance Abuse Prevention and Treatment Agency, you have the right to a determination of fees according to a sliding fee schedule of fees that is contingent upon your providing verifying information. Such documentation should be provided at the intake session at which your share of costs is determined. **Client must provide documentation of income prior to or during assigned orientation.** If a client cannot provide proof of income, or if a client is indigent/homeless, we require a signed, written statement as proof of such. If a client can provide a letter from another social service agency/shelter of indigence, then fees will be assessed based on $0 income. If a client qualifies for the sliding fee scale, then his/her session fees will be lowered appropriately. The processing fee is $25.00 and is not valid for the Sliding Fee Scale, however if you are not able to pay the full amount of the evaluation fee at this time, you may make payment arrangements with authorized staff.

To qualify for the Sliding Fee Scale, you **MUST** bring in proof of income documentation for **ALL** income you and any members of your household may receive. Examples of this documentation include W-2 forms, tax returns, last two check stubs, bank statements, letters of award, etc.

Do you receive money/support from ANY of the following sources? If YES, please check EACH source from which you receive support?

☐ Wages/Unemployment/Cash/Tips/Social Security/SSI/Retirement

☐ Student Grants/Scholarships/Loans

☐ Welfare/TANF/Food Stamps/Subsidized Housing

☐ Alimony/Child Support

☐ Other (please describe): _________________________

For Office Use Only:
____
____

By signing this form, I affirm that I understand and accept Community Counseling Center's fee determination policies. I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Please read carefully:

- Once the fee has been determined by the above process, refusal to pay may result in discharge from the program per state of Nevada Division of Mental Health & Developmental Services.
- A twenty-five ($25.00) dollar non-sufficient fund (NSF) fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time it may be referred to a collection service for recovery.
- We do not accept out of state checks or check for final payment of your bill.

COMMUNITY COUNSELING CENTER CONFIDENTIAL CLIENT INFORMATION

AUTHORIZATION TO RELEASE INFORMATION TO AND COLLECT PAYMENT FROM INSURANCE

Patient: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

Relation to insured: ______________________________

Insurance Company: ______________________________

Insurance Company/Address/Phone: ______________________________

____

Group: ______________________________

Employer: ______________________________

Insured ID: ______________________________

Other ID: ______________________________

Other Insurance: ______________________________

I hereby authorize Community Counseling Center to release information to my insurance provider about the diagnosis and the therapeutic services provided to me (or to the above-named patient, if a minor). I also authorize my insurance provider to remit payment directly to Community Counseling Center.

______________________________ ______________________________
Name (Printed) Signature

____
Date

Information provided pursuant to this release is protected by all applicable confidentiality regulations. Further release of this information requires specific authorization by the client.