Center for Positive Change, Inc.

Consumer Demographic Information

Consumer Name:_____ ID# *(office use only)*:_____
(last, first, MI)

SSN:_____ DOB:_____ Sex: _____ Race:_____ Other: _____
(optional)

Street Address:_____ City:_____ State:_____ Zip: _____

Mailing Address (if different): _____

Home#:_____ Cell#:_____ Other#:_____ Email address: _____

School or Employer:_____ Address:_____ Phone#:_____

Employment Status: Student

Primary Responsible Party's Information (Required if consumer is a minor)

Name:_____ DOB:_____ SSN:_____ Phone#: _____

Employer:_____ Phone# & Address: _____

Relationship to Consumer: _____

Secondary Responsible Party's Information

Name:_____ DOB:_____ SSN:_____ Phone#: _____

Employer:_____ Phone# & Address: _____

Relationship to Consumer: _____

Primary Insurance Information

Insurance Company:_____ Policy Holder:_____ DOB:_____ SSN: _____

Policy ID#:_____ Group#:_____ Relationship to Consumer: _____

Secondary Insurance Information

Insurance Company:_____ Policy Holder:_____ DOB:_____ SSN: _____

Policy ID#:_____ Group#:_____ Relationship to Consumer: _____

I certify with my signature below that the information provided above is true and accurate, and I will give proper notification of any changes or updates that may occur.

_____ _____
Consumer Signature *(required if 14yr or older)* Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Provider Signature/Credentials Date

Client Services Planning Worksheet
Reason for Seeking Services

Please fill out this worksheet completely. This worksheet will be used as a tool by your provider to aid in your treatment.

Consumer Name: _____ Date: _____

Are you experiencing any of the following issues? Please mark all that apply:

☐ Depression	☐ Anger	☐ Physical Abuse	☐ Home Problems	☐ Family Conflict	☐ Suicidal Thoughts
☐ Runaway	☐ Anxiety	☐ Sexual Abuse	☐ Domestic Violence	☐ Blended Family	☐ Suicidal Attempts
☐ Marital	☐ Pre-Marital	☐ Death in Family	☐ Severe Injury/Accident	☐ Spiritual	
☐ Divorce	☐ Self-Esteem	☐ Death of a Friend	☐ Employment Problems	☐ Codependency	
☐ Bullying	☐ Grades	☐ ADHD	☐ Attendance	☐ Other School Problems	
☐ Financial	☐ Fighting	☐ Empty Nest Syndrome	☐ Gambling	☐ Law Violation	
☐ DUI	☐ Assault	☐ Possession	☐ Vandalism	☐ Shop Lifting	

☐ Other _____

Drug/Alcohol Problems (Self):

☐ Beer	☐ Hard Liquor	☐ Cocaine	☐ Heroin	☐ Methamphetamine
☐ Oxycontin	☐ Ecstasy	☐ Steroids	☐ Marijuana	☐ Suboxone/ Methadone

☐ Other _____

Drug/Alcohol Problems (Spouse):

☐ Beer	☐ Hard Liquor	☐ Cocaine	☐ Heroin	☐ Methamphetamine
☐ Oxycontin	☐ Ecstasy	☐ Steroids	☐ Marijuana	☐ Suboxone/ Methadone

☐ Other _____

Drug/Alcohol Problems (Other Family Members):

☐ Beer	☐ Hard Liquor	☐ Cocaine	☐ Heroin	☐ Methamphetamine
☐ Oxycontin	☐ Ecstasy	☐ Steroids	☐ Marijuana	☐ Suboxone/ Methadone

☐ Other _____

What issues would the client like to be addressed while receiving services from CPC?

_____

_____

What issues does the client feel need to be improved upon?

_____

_____

How long does the client anticipate needing counseling services to overcome these difficulties?

_____

_____

What types of services does the client feel would be important to receive while at CPC?

☐ Individual Counseling ☐ Family Counseling ☐ Group Counseling ☐ Alcohol/Substance Abuse ☐ Other _____

How often would the client like to meet with their service provider to receive services from CPC?

☐ 1 x week ☐ 2 x week ☐ 1 x every two weeks ☐ 1 x month ☐ Other _____

ID # _____

Center for Positive Change, Inc.

Consent for Treatment and/or Transfer of Services

Consumer Name:_____ Consumer ID#: _____

Application is hereby made by the undersigned for voluntary admission to the outpatient behavioral health services of Center for Positive Change, Inc. as a voluntary consumer under the provision of *43A OK Stat §43A-9-101 (2014)*.

Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Minor consumers may be admitted on application of parent, guardian, or the person having custody, pursuant to the provisions of *43A OK Stat § 43A-9-101 (2014)*. A minor may apply for voluntary treatment, pursuant to the provisions of *63 OK Stat § 63-2602 (2014)*.

All persons receiving services from this facility shall retain the rights, benefits, and privileges guaranteed by the laws and constitutions of the State of Oklahoma and the United States of America, except those specifically lost through due process of law, *43A OK Stat § 43A-1-103 (2014)*

- All persons shall have the rights guaranteed by the *Substance Abuse Consumer's Bill of Rights*, unless an exception is specially authorized to these standards or an order of a court of competent jurisdiction.
- I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.
- I understand that my provider participates in treatment team, in which providers within the agency consult with one another to ensure quality of care to consumers.
- I have been given a summary or full copy of my rights as a consumer and fully understand the content of this document.
- I have read, or had read to me, the above information about my rights.
- I have read, understand, and agree to the terms set forth in the Consumer Handbook provided to me. I understand and agree that by not complying with the terms set forth in the Consumer Handbook may lead to termination of services with Center for Positive Change.

I,_____, wish to begin services with Center for Positive Change, Inc. with the effective date of_____. If other mental health agencies are involved, I will be advised of my right to collaborate or terminate with that agency.

Consumer/Client Signature *(required if 14yr or older)* Date

Parent/Guardian Signature Relationship to Client Date

Provider Signature/Credentials Date

Center for Positive Change, Inc.

Acknowledgement of Receipt of Consumer Handbook

Consumer Name:_____ Consumer ID#: _____

By initialing the following headings found in your consumer handbook, you verify that you received, understand, and agree to abide by the terms and conditions found in each section throughout the course of your treatment with CPC.

_____ I. Mission, Philosophy, and Values

_____ II. Office information

_____ III. Code of Ethics

_____ IV. Consumer Rights

_____ V. Confidentiality, HIPPA, and 42CFR

_____ VI. Grievance Policy and Procedure

_____ VII. Consumer Orientation, including expectations, discharging, and transitioning from services

_____ VIII. Financial Policy

_____ IX. Health and Safety, including TB/HIV/AIDS/STI education

_____ Initials acknowledge that the consumer participated in a face-to-face (check one): Biopsychosocial ☐ or Client Assessment Record ☐.

Does CPC have your permission to contact you, the consumer, (by phone, mail, or email) regarding your status and to answer some questions concerning satisfaction of services received upon termination of services? Please initial a choice. Yes No

I understand that if I have granted permission for CPC to contact me after services are terminated that I can revoke this consent at any time by giving written notice to CPC or by refusing to participate in any follow-up questionnaire. Follow-up is the same for all persons served regardless of referral status.

Center for Positive Change, Inc. (CPC) is a fee for service provider. I understand that it is the responsibility of the consumer to provide CPC with updated and accurate information, including most current insurance information. Any outstanding balances such as co payments and/or deductibles are due at the time of service. I understand that the consumer is responsible for any charges not covered by the benefits of insurance or healthcare coverage. I understand that by signing below, I (the consumer) am authorizing CPC to submit claims for benefits on my behalf and am authorizing the release of any information relating to claim submission for services rendered.

I, the consumer, acknowledge that I have received a copy of the Consumer Handbook which has been communicated to me in a meaningful way. I, the consumer, have read and understand this document in its entirety and further certify that I agree to the terms and provisions stated herein. I, the consumer, acknowledge that I have been advised of the right to an advance directive and the right to a treatment advocate. I further understand that these policies may change from time to time and every effort will be made to communicate significant changes to consumers.

_____ _____

Consumer/Client Signature *(required if 14yrs or older)* Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Provider Signature/Credentials Date

Center for Positive Change, Inc.

Consent for Release of Confidential Information

Consumer Name: _____ DOB: _____ Consumer ID#: _____

I, the consumer, authorize Center for Positive Change, Inc. and the following agencies, entities, or people to release and disclose to one another the following types of information:

Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re- disclosure by the recipient, resulting in the information no longer being protected.
This consent is valid from:

(Start Date) _____ to (end date) _____ (One year period minus one day)

Each individual organization requires separate form.

Release information to or from (List specific person(s), title/position, and address):

Name(s): _____

Address: _____

_____

Purpose of release (be as specific as possible): _____

_____

_____

Items to be released (be as specific as possible): _____

_____

_____

I understand my medical records and all clinical information are confidential and are protected under the provisions of 43A OS & 1-109. I understand medical records and all communications between consumer and doctor or psychotherapist are privileged and confidential; with such information limited to persons or agencies actively engaged in my treatment or related to administrative tasks. I understand privileged and confidential information shall not be released without my written, informed consent. I understand that treatment is not contingent upon or influenced by my decision to permit this information release. My consent is given freely and voluntarily. **The information authorized for release may include records, which may indicate the presence of a communicable or non communicable disease, or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). (63 O.S. SEC. 1-1502(B)). If any criminal proceeding is involved, disclosure is bound by federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. #290DD-2; 42 C.F. R., Part 2) and recipients of the information may receive and disclose it only in connection with their official duties with respect to the particular criminal proceeding and may not use the information in other proceedings, for other purposes, or with respect to other individuals.**
I understand that I may revoke this consent in writing at any time by signing and dating the revocation line at the bottom of this page, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year following the date I stopped receiving services from Center for Positive Change, Inc.
Revocation must be submitted to your therapist. However, if any criminal proceeding is involved, this consent is irrevocable until final disposition of the proceeding, and expires upon final disposition of the proceeding.

Consumer/Client Signature *(14 or older)*: _____ Date _____

Parent/Guardian Signature: _____ Date _____

Staff/Witness Signature: _____ Date _____

I hereby revoke this consent: _____ Date _____

Center for Positive Change, Inc.

Right to Name a Treatment Advocate

Consumer Name:_____ Consumer ID#: _____

All adult mental health consumers being served by a licensed mental health professional have the right to designate a family member or other concerned individual as a Treatment Advocate. The choice to name an advocate is the consumer's alone. In the event an advocate is chosen, the level of involvement of the advocate is to be determined by the consumer and no limitation may be imposed on a consumer's right to communicate by phone, mail or visitation with the established Treatment Advocate. The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consented to by the consumer and permitted by law. The consumer may revoke the designation of a treatment advocate at any time and for any reason. In some instances, it may be appropriate for a minor consumer to have a treatment advocate designated, this should be discussed with your provider.

Would you like to name a Treatment Advocate? ☐ Yes ☐ No

Please list the name and phone number of the person you wish to choose as a Treatment Advocate:

Name: _____ Phone (Include area code): _____

Please indicate the level of involvement the identified Treatment Advocate shall have:

- ☐ Should the advocate be present during intake?
- ☐ Would you like the advocate to help you with the treatment planning?
- ☐ Do you want the written treatment plan information provided to the advocate?
- ☐ Should we notify the advocate only if there are changes to the treatment plan?
- ☐ Would you like the advocate to be present at all of your sessions?
- ☐ Other:

_____

_____
Signature of Consumer/Client *(required if 14yr or older)* Date

_____
Signature of Parent/Guardian Date

For the Treatment Advocate:

I intend to serve as Treatment Advocate for the above named consumer. I have received a copy of the The Center for Positive Change confidentiality standards and I agree to serve according to the consumer's specifications and comply with all standards of confidentiality.

_____
Signature of Treatment Advocate Date

_____
Provider Signature/Credentials Date

Center for Positive Change

Consumer Satisfaction Survey

Therapist Name:_____

Date: _____

New Consumer/Client or stakeholder ☐ Current Consumer/ Client or stakeholder ☐ Discharging Consumer/ Client or stakeholder ☐ Former Consumer/Client or stakeholder ☐

1 = Strongly Disagree | 2 = Disagree | 3 = Slightly Agree | 4 = Agree | 5 = Strongly Agree

My counselor kept my scheduled appointments and was on time.

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

CPC staff responded to and addressed my/the consumer's needs promptly.

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

CPC staff are respectful, ethical, and responsive to my needs/the consumers, or stakeholders.

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

I felt my concerns were handled in a confidential manner.

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

I have benefited from the services I have received from CPC.

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

What services would you like to see CPC provide in the future? _____

How many discipline referrals have you received from school/work in the last 90 days? _____

How many absences have you had from work/school in last 90 days? _____

How many times have you been intoxicated in the last 90 days? _____

How many times do you use tobacco on a daily basis? _____

How many angry outburst have you had in the last 90 days? _____

What is your current employment status? (ex: student, employed, unemployed) _____

What is your Race/Ethnicity? _____ What is your age? _____

Please rate your self esteem: 1=low, 5=high

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

Please rate the quality of your relationships: 1=low, 5=high

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

How would CPC improve current services? _____

Would you like someone from CPC to contact you about this survey? ☐ Yes ☐ No

If yes, please provide your name and phone number: _____

Or Email Address:_____

Center for Positive Change, Inc.

Consumer Orientation Checklist

Consumer Name:_____ Consumer ID#: _____

Initialing below indicates that the consumer has been provided with corresponding information, understands, and agrees to the terms and conditions therein.

___ Consumer Demographic Information

____ Copy of Consumer's Driver's License *(parent/guardian if consumer under 18yrs. old)*

____ Copy of Consumer's Current Insurance Card *(parent/guardian if consumer under 18yrs.)*

___ Consumer Handbook and Acknowledgment of Receipt

___ Consent to Treatment Form

___ Treatment Advocate Form

___ Consent to Release Confidential Information

___ Provider's Professional Disclosure

___ Consumer Orientation Checklist

___ Consumer Satisfaction Survey

___ Consumer has been oriented to the building, including emergency procedures

Once the intake process is complete, you will actively participate in the development of your treatment plan which consists of your goals for treatment based on your needs and preferences. You and your provider will also develop discharge criteria as part of your plan for treatment.

You understand that your signature below authorizes the release of any information relating to all claims for benefits submitted on your behalf, or that of your dependent (if consumer is a minor). You further understand and agree that your signature on this document authorizes CPC to submit claims for all benefits, for services rendered, and for services to be rendered, without obtaining your signature on each and every claim to be submitted on your behalf, or that of your dependent. You understand that you will be bound by this signature as though you had signed each and every claim submitted on your behalf, or that of your dependent, through services received with CPC.

_____ _____

Consumer/Client Signature *(required if 14yr or older)* Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Provider Signature/Credentials Date