Adult Intake Packet

Client Information **Today's Date: _____**

First Name: _____ **Middle Name**: _____ **Last Name**: _____

Note: Please spell name as spelled on your insurance card

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email: _____ **Age**: _____ **DOB**: _____ **SS#**: _____-_____-_____

☐By check marking this box, you are giving Tueller Counseling Services permission to contact you via electronic forms of communication (i.e. text and/or email).

Primary Language: _____ **Do you need an interpreter?** ☐Y ☐N **Location to be seen**: _____

Gender Identity: ☐ Male ☐Female ☐ Transgender ☐Genderqueer ☐Declined ☐ Other_____

Employer: _____ **Employer contact and #:** _____

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Partner ☐ Widow ☐ Remarried (# of times _____)

☐ Other _____

Note: If divorced, please supply us with legal documentation of custody to ensure that privacy rights can be enforced.

Ethnicity: ☐Native American ☐African American☐ Latino☐ Asian☐ Pacific ☐Caucasian ☐Other_____

Emergency Contact Information ****Will only be contacted in case of an emergency. If you would like this individual to receive information regarding services, please fill out a Release of Information****

Name: _____ **Number**: _____ **Relationship**:_____

Name: _____ **Number**: _____ **Relationship**:_____

Referred by: _____ **What reason?** _____

Insurance Information: ****Please bring all insurance cards and photo ID to the 1st appointment****

Primary Insurance Carrier:

Name: _____

Phone: _____

Policy holder (PH):_____

Relationship of PH to you: _____

PH DOB: _____ **PH SS#**_____

Policy ID: _____

Group #: _____

Secondary Insurance Carrier:

Name: _____

Phone: _____

Policy holder (PH):_____

Relationship of PH to you: _____

PH DOB: _____ **PH SS#**_____

Policy ID: _____

Group #: _____

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Health Insurance Waiver/Self-Pay Agreement **Please Initial the one that applies to you**

_____**INSURED:** I understand that Tueller Counseling will bill my insurance as a courtesy. I understand that I will be responsible for any remaining balance that my insurance company does not cover. Including any deductible, coinsurance, co-payments, etc.

_____**BPA Funding**: I understand that I can use BPA funding as long as I have a current authorization and that Tueller Counseling will inform me when that authorization will be coming to an end.

_____**UNDERINSURED and UNINSURED:** For any services provided outside my plan limits, I agree to pay in full. ***(Sliding Fee Discount Program available)***

_____**SELF-PAY:** I understand that as of the date of service I am not eligible for coverage under my insurance. I choose to receive services provided and agree to pay out of pocket. I have decided at this time to not utilize my health insurance to cover the cost of services received through Tueller Counseling. I opt to be fully responsible for payment for all charges incurred.

_____**INTERN**: I understand that as of the date of service I will be receiving services from a supervised intern at Tueller Counseling. Intern services are free of charge. However, if at any time, I choose to be seen by a licensed clinician, I understand that I will be fully responsible for payment for all charges incurred.

_____**THIRD PARTY AGREEMENT:** I understand that where I am over 18 years of age, if another party (Parents, Bishop, Family Crisis Center, Etc.) agree to be financially responsible for counseling services I receive through this provider, that I must provide written documentation of our financial agreement in the form of a letter. This letter must include contact information, number of sessions approved, and payment arrangement. I understand that in the event that I do not furnish the letter I am ultimately responsible for full payment of services rendered. (Bishop Clients) I understand that I need to provide Tueller Counseling with a letter from my Bishop. The letter must contain my Bishop's contact information (Name, Phone Number, Address, Ward, Stake) as well as the specific payment arrangements.

_____**INSUFFICIENT PROOF OF COVERAGE:** I understand that I have arrived at my appointment without sufficient proof of insurance (discrepancy in insurance coverage/invalid insurance card). I am aware that ultimately, I am responsible for services rendered at this time and choose to receive them willingly. If I provide sufficient proof of being insured *within in a **timely** manner* (within 5 Business Days), I understand that I may be reimbursed for payment of today's services after my claim has been processed and paid for by the insurance. If I do not provide proof of insurance within a timely manner I understand that I will be responsible for today's visit in full.

I acknowledge that I have had the opportunity to receive and understand the Financial Policy of Tueller Counseling Services, Inc. and agree to the policy.

Client Name: _____ Signature: _____ Date: _____

Financial Policy Acknowledgement

Tueller Counseling Services, Inc. is dedicated to providing the best patient-centered care, ensuring our clients have improved access to care, and making sure that no client will be denied behavioral health services due to an inability to pay. We provide discounted care to those who are underinsured or uninsured – *Ask us about our Sliding Fee Discount Program*.

We participate in most major health plans. We have contracts with many insurance companies and government agencies including Medicare and Medicaid. Our office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid.

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Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. You may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after contractual insurance adjustments, will be billed to you. For your convenience we accept cash, check or the following credit cards: Visa, MasterCard, American Express (AMEX) and Discover. If you do not have your co-payment, your appointment may be rescheduled.

If, for some reason, your insurance processes a claim Out of Network, the patient is still financially responsible for any charges accrued.

It is the client's responsibility to provide all necessary insurance/ financial information and/or updates to Tueller Counseling at each date of service.

It is the policy of Tueller Counseling Services, Inc. to treat all patients in an equitable fashion related to account balances. We will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with insurance companies. Full or partial financial responsibility may only be waived in accordance with the practice's Sliding Fee Schedule Policy.

Please note:

- Payment is due at the time of service.
- Payment plans are available upon request.
- Please bring your insurance card with you at the time of your appointment.
- If you are insured but don't have an insurance card with you, payment in full for each visit may be required until we can verify your coverage.
- Any discharged clients' balances that are more than 65 days overdue may be considered for collections (*in compliance with the Idaho Patient Act: Chapter 3 Title 48).*
- A no-show fee of $40.00 will be charged, if:
- You do not show for a scheduled appointment
- You do not contact the clinic within 2 hours (*or before your apt if your apt time is within 2 hours of opening*) to cancel your appointment
- You are more than fifteen minutes late to your appointment
- The no -show fee is due before or on your next visit

By signing this document, I acknowledge that I have read and understand the Tueller Counseling Services, Inc. Financial Policy.

Client Name: _____ Signature: _____ Date: _____

Medicare/Medigap

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statements:

I request payment of authorized Medicare Benefits to me or on my behalf for any services furnished me by or in Tueller Counseling Services, Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.

Client Name as it appears on Medicare card: _____

Signature: _____ Date: _____

A MEDIGAP Policy is a supplemental policy that covers the remaining 20% that Medicare does not. If you have such a policy, we are required by Medicare to Keep a second signature on file.

I request authorized MEDIGAP benefits to be made on my behalf to Tueller Counseling Services, Inc. for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Client Name as it appears on Medicare card: _____

Signature: _____ Date: _____

Acknowledgement of Orientation Manual

By signing this document, I acknowledge that I was given an opportunity to review the Tueller Counseling Services Inc. Orientation Manual, which includes the following items:

- Things you need to know
- What to expect from Community Services?
- Attendance and Cancellation Policy
- Transportation Information
- Staff Information
- Financial Policy
- Client's Legal and Human Rights
- Complaint & Problem-Solving
- What to expect from counseling?
- Notice of Privacy Practices: HIPAA
- Crisis Planning

I was given an opportunity to ask questions regarding the services available to me and the policies outlined above.

Client Name: _____ Signature: _____ Date: _____

Animal-Assisted Therapy/Service Animal Release

Definitions:
Therapy Animal: Animal-Assisted Therapy (AAT) or Animal Assisted Intervention (AAI) is a form of creative therapy that utilizes licensed and credentialed therapy animals with a licensed therapist/animal handler to provide goal-directed interventions to individuals of all ages. AAT can be used with various types of emotional, developmental, cognitive, motivational, or physical impairments.

Service Animal: Dogs that are individually trained to do work or perform tasks for people with disabilities. Service animals are working animals, not pets and not therapy animals. The work or task a dog has been trained to provide must be directly related to the person's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

☐ Yes, I am willing to receive services from a provider that utilizes a therapy animal or that has a service dog. Please sign the acknowledgement below.

☐ No, I am not comfortable with animals and wish to be with a provider who does not utilize service or therapy animals.

The purpose of this form is to review the policies, procedures, and risks of working with a therapy dog, as well as request your consent for treatment utilizing AAT or the presence of a service dog.

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Policies, Procedures, and Risks for Working with Animals in Therapy

Although working with animals, specifically canines, in a therapeutic setting has many benefits, there are risks associated with the intervention. Because AAT utilizes a live animal, it is important to note in advance the policies and procedures needed to maximize the intervention and ensure a safe work environment, both for the animal and client.

1. AAT and service animals are two separate classifications. Service animals are NOT to be used as a therapeutic tool.
2. Participation in AAT is not guaranteed and will be based on assessment. If the assessment determines the client is not a good fit, other treatment options will be discussed and appropriate referrals may be made.
    a. If a history or indication of animal abuse or other risk factors are present, it will determine whether participation in AAT is indicated
    b. Should a client become aggressive (hits, kicks, bites, pulls, punches etc.) during therapy, will determine if it is appropriate to continuous treatment or make the appropriate referrals.
3. All patients must either wash their hands, use hand sanitizer or sanitizing wipes before and after touching the animals.
4. Clients are never left alone with animals.
5. Animals cannot be used in therapy without the handler present. No other provider, unless credentialed and previously approved, can handle or use an animal in a therapeutic capacity.

I understand and agree to the policies, procedures, and risks associated with the use of Animal-Assisted therapy in psychological treatment and/or the presence of a service dog. I hereby consent to therapeutic services involving a registered therapy dog or service dog, and accept full liability. Furthermore, I am not aware of any fear, allergy, skin or respiratory sensitivity, or other medical condition I/we have that would render physical interaction (i.e. touching, handling) with or close proximity to a therapy/service dog potentially harmful to my/our health.

Client Name: _____ Signature: _____ Date: _____

Medical Release Form – Statement and Consent

In the event if an emergency or non-emergency situation requiring medical treatment, I,_____ hereby grant permission for any and all medical and/or dental attention to be administered to my child/self, in the event of an accidental injury or illness, until such time as an emergency contact can be reached. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Client Name: _____ Signature: _____ Date: _____

Refusal of ConsentPrint Name**: _____ **Signature**: _____ **Date**: _____

Information Disclosure and Consent

Purpose: To provide a safe, structured environment that is supportive in which to explore individual needs, concerns, and goals.
Hours services are provided: Normal office operating hours are Monday through Friday from 9:00am-6:00pm. In the event that services are provided outside this time frame, the client and parent is notified and agree upon meeting times.
Confidentiality: Information disclosed to a licensed counselor is a privileged communication and cannot be disclosed in any civil or criminal court proceeding in Idaho without the consent of the client. However, under the Idaho Rule of Evidence 517(d) there is no privilege for the following acts:

- Civil Action: In a civil action case or proceeding by one of the parties to the confidential communication against each other.

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- Proceedings for guardianship, conservatorship, hospitalization: As to a communication relevant to an issue in proceedings for the appointment of a guardian or conservator for a client with mental illness, or to hospitalize the client for mental illness.
- Child-related communications: In a criminal or civil action or proceedings as to a communication relevant to an issue concerning a physical, mental, or emotional condition of or injury to a child, or concerning the welfare of a child including, but not limited to, the abuse, abandonment, or neglect.
- Licensing board proceedings: In an action case or proceeding under Idaho Code 54-3403.
- Contemplation of crime or harmful act: If the communication reveals the contemplation of a crime or intention to commit a harmful act.
- Insurance, Medicaid, and other payment companies: Information needed for billing purposes.

Release of Information: Information pertinent to care and treatment may be released to insurance companies and other entities for reimbursement purposes, as well as others indicated on signed releases, to be updated annually.

Fees: The private pay fee for services is $200 for initial intake appointment, $70 for 30 minute session, $120 per hour individual session and $120 for family session, and $25 per hour for group. Portions of rendered services may also be covered by insurance, Medicaid, Medicare, etc. The fee for services is $0.00 per Medicaid. Fees for insurances will vary depending on eligibility and benefits of the client.

Documentation: Documentation is maintained regarding the services received through Tueller Counseling Services Inc. These records are confidential and cannot be released without your consent. You have the right to access your clinical records.

Professional Standards: Professionals adhere to the NASW code of ethics. The bureau of occupational licensing regulates the practices of professionals. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of the treatment.

Second Opinion: At any time in treatment, you may seek a second opinion. It is the responsibility of the client to choose the provider. The client may terminate services at any time unless treatment is court-ordered.

Time-out and Restraints: Fostering healthy relationships and adaptive social behaviors is role-modeled, taught, and practiced. When behaviors are dangerous or noncompliant, time out and sentences are used as negative consequences. If a client becomes dangerous to themselves, others, or property, a human restraint is implemented by those qualified.

Medication Administration: Administration of medication may be provided as directed by a doctor, by qualified personnel.

Transportation: Transportation to mental health services may be provided by parental choice of transportation to Tueller Counseling Services Inc. **Risks:** Treatment is not guaranteed to cause positive results. Risks of treatment may include worsening of behaviors, conditions preceding potential improvement.

Allowing Pickup of Child: Referring to the Intake Assessment, those listed are approved to pick up my child.

Emergency/Crisis Plan and Resolution: In the event of an emergency, call 911 or go to your local emergency room. Crisis Line available 24/7/365 at (208) 520-9630.

Right to Refuse Services or Choose Alternate Provider: Treatment may be refused or consent revoked at any time, if desired by the client. There are many providers from which to choose. Tueller Counseling Services Inc. is only one of those providers.

Statement of Understanding: I understand my rights as a client and have asked any questions regarding the above information. I willingly agree and consent to treatment through Tueller Counseling Services Inc. with the understanding of the previously stated disclosures.

Notice of Privacy: We are dedicated to protecting your confidential information. We create records of the services provided and forwarded copies of records provided by other service providers. We are required to use and disclose confidential information as required by law, maintain the privacy of your information, give you this notice of our legal duties and privacy practices for your information, and to follow the terms on the current HIPPA guidelines that are currently in effect.

Right to Review and Copy: You have the right to review and copy your clinical information as allowed by law. You may request any documentation completed by Tueller Counseling Services Inc. Information provided by another agency or entity will need to be requested from that agency or entity. You may be subject to a fee to cover any costs associated with the request.

Right to Amend: You have the right to ask to make changes to your information if you feel the information we have is incorrect or incomplete. A Request of Amend Records form is available for your use. You must complete the form and return it to the front office for processing. Our office will respond to your request within 10 days. We may deny your request if you ask us to change information when the document was not created in our office, when the information is derived from a court document, when the data is historical in nature and is from the perspective of a biological family member or a member within the family, when we

determine the information in court ordered mental health assessment completed by a clinician is an objective cultural representation of the client's current mental health information and diagnosis currently at this time.

Prohibition of Re-disclosure statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse of patient.

Client Name: _____ Signature: _____ Date: _____

Telehealth/Telephonic Informed Consent

I _____, consent to receiving counseling sessions via telehealth. I understand that the telehealth/telephonic platforms (Clocktree and Zoom) being used by Tueller Counseling Services, Inc. are HIPAA compliant.

I understand that the purpose of telehealth/telephonic is to provide quality service over a distance as a service to me as the client. Iunderstand that I am responsible for keeping my session private and HIPAA compliant at the originating site (where the client is located). I understand that I can receive telehealth/telephonic services only in states where my provider is licensed to practice (or as a state mandate allows). I understand that I am responsible for disclosing my location to my provider to ensure that I can receive services ethically without putting the provider's license at risk. I understand that my provider will refuse services if disclosed that I am located in a place that they are not licensed to practice. I also understand that the financial policy and attendance policy are still in effect with telehealth/telephonic.

By signing this form, I acknowledge that I understand and agree with the above conditions.

Client Name: _____ Signature: _____ Date: _____

Medication Management/Dr. Ronald Zohner Agreement

*Please initial that you acknowledge and agree to the following policies:

— Dr. Zohner accepts clients ages 5+
— For clients with commercial insurance visits are subject to deductibles and copays. Private pay fees are as follows: New child- $600, New adult - $475, Follow-up $200.
— Dr. Zohner is only in our offices a few days a month. It is best to think ahead and reschedule your follow up appointments right away preferably following your appointments, or you may be subject to having a longer wait time for your next follow up appointment.
— New adult appointments are scheduled for an hour.
— New child appointments are scheduled for an hour and a half. Parent/legal guardian must attend all appointment with the child or teen. NO EXCEPTIONS!
— Follow up appointments are scheduled for 30 minutes. If a client is more than 10 minutes late the appointment will need to be rescheduled.
— Clients must be seeing one of the counselors within our agency consistently for 3-4 appointments prior to being put on Dr. Zohner's schedule. Exceptions are made in extreme cases.

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- Once on Dr. Zohner's schedule, clients must continue seeing a counselor twice a month or the appointment may be cancelled with the option to reschedule after the client has been seen by their counselor. This is non-negotiable. Office staff will contact the client/guardian before moving the client from the schedule.
- Clients should receive a confirmation call a day or two prior to the appointment. The client must confirm the appointment to stay on the schedule for the day of the appointment. Space on Dr. Zohner's schedule is limited and fills up fast. We do have a waitlist in case of cancellations.
- Two no-shows and client will no longer be eligible to see the psychiatrist through our agency. No-show visits are also subject to a fee of $200.00-$300.00 per missed visit.
- Please let the office staff know of cancellations at least 24 hours in advance so that we can try to fill the time with another client from the waitlist.
- Please remember to let the office staff make a copy of any prescriptions at check out. This is also a great time to schedule your follow up appointment.
- If you have any prescription refills or medication reactions, please call Dr. Zohner's office at (208) 552-5707.
- Appointments may be subject to change from in person to telehealth. I have read and acknowledged the Telehealth Consent Form.
- I have reviewed and acknowledge the terms and conditions of this agreement.

Client Name: _____ Signature: _____ Date: _____

****Refusal of consent**** **Signature: _____ Date: _____**

Reason for refusal, if applicable: _____

Mental Health Providers

I understand that I may choose any agency to provide services. I have chosen to be provided services at Tueller Counseling Services, Inc.

Client Name: _____ Signature: _____ Date: _____

Intern or Wait List

I understand by selecting Tueller Counseling Services I have been offered to be referred out to another agency and accept being placed with an intern or on the wait list if a counselor is not available at the time of this signature.

Client Name: _____ **Signature**: _____ **Date**: _____

Consent for Intern or Shadow

Tueller Counseling Services participates in educational programs with area colleges and universities to give students engaged in coursework related to the counseling field experience in clinical practice and community work. Tueller Counseling employees have agreed to permit students to observe and participate in client care under the employee's direct supervision.

_____ (initial) I agree to permit students to observe
_____ (initial) I DO NOT agree to permit students to observe

Client Name: _____ Signature: _____ Date: _____

Adult Intake Packet

Release of Information

I give permission to release my medical/mental health information to be disclosed for purposes of communicating results, findings and care decisions to the establishments listed below:

Name	Relationship	Phone Number
Tueller Counseling SUDS Department	SUDS Health Services	208-524-7400

Client may revoke or modify this specific authorization – the revocation or modification must be in writing.

Client Name: _____ **Signature:** _____ **Date:** _____
Refusal of Consent Signature: _____ Date: _____

Survey

I acknowledge that I may be asked to participate in surveys to better the services at Tueller Counseling Services.

Client Name: _____ **Signature:** _____ **Date:** _____

Medical Information **Accurate information assists the provider with determining appropriate care**

Patients' Primary Care Physician: _____ **Most Recent Visit**: _____

Previous Mental Health/Substance Use Disorders Treatment

Have you ever been a client at Tueller Counseling Services? ☐Y ☐N
If yes, When? _____ **Provider name?** _____
Are you currently receiving any community services at another agency? ☐Y ☐N If yes, please provide name of service, provider name, contact information, agency name and ROI (see ROI at end of packet)

_____
_____

Medications Currently Prescribed **Accurate information will expedite assignment of medical provider**

Physical Health Medications	Dose	Mental Health Medications	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

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Substance Abuse History

Check all that apply within the last 6 months.

- ☐ Tobacco
- ☐ Caffeine
- ☐ Alcohol
- ☐ Marijuana
- ☐ Cocaine/crack
- ☐ Ecstasy
- ☐ Heroin
- ☐ Inhalants
- ☐ Methamphetamines
- ☐ PCP/LSD
- ☐ Spice
- ☐ Bath Salts
- ☐ Prescription Pain Meds
- ☐ Prescription Anxiety Meds

Presenting Problems and Concerns

Describe the concern that brought you here today:

_____

_____

_____

Adult Behavior Checklist **Mark any words that apply**

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/Confusion
- ☐ Season Mood Changes
- ☐ Sadness/Depression
- ☐ Loss of pleasure/Interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/Shame
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal form people
- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear ways from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/Fights
- ☐ Frequent arguments
- ☐ Irritability/Anger
- ☐ Homicidal Thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/Paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories
- ☐ Other: _____

Client Name: _____ **Signature:** _____ **Date:** _____

Legal

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, explain: _____

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Are you currently on Probation/Parole? ☐ Yes ☐ No If yes, with who?_____

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No If yes, please provide documentation.

Advanced Directive

Do you have a psychiatric advanced directive? ☐ Yes ☐ No

Are you interested in receiving information on creating a psychiatric advanced directive? ☐ Yes ☐ No

Adult Intake Packet
Release or Exchange of Information

Client Name: _____ **Client Date of Birth**: _____

****Please INITIAL each category that applies. Do not leave any space blank. Write N/A (not applicable)****

This certifies that I hereby authorize Tueller Counseling Services, Inc to:

_____ Release information to _____ Obtain information from _____ Exchange information with

Primary Care Physician: _____

****Only 1 person/entity may be written here. Please fill out a different ROI for each person/entity****

Specific Information to be released:

_____ Dates of treatment
_____ Assessments/Evaluations
_____ Psychiatric and treatment record
_____ Progress and behaviors
_____ Health Connections Referral/History and Physical
_____ Treatment Planning
_____ Oral communication as needed
_____ Other as specified: _____

For the following purpose:

_____ Coordination of treatment/care _____ Academic considerations _____ Other: _____

In understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) Any revocations must be delivered in writing to each of the treatment providers listed above. I also understand that my records are protected under specific Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I understand that Tueller Counseling Services, Inc. is released from all legal liabilities which may arise from the release of this information.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent anytime, by either written or verbal notification, except to the extent that action has been taken in reliance on it.

****THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE****

Print Name: _____ Signature:_____ Date: _____

Refusal of Consent Signature: _____ Date: _____

Adult Intake Packet
Release or Exchange of Information

Client Name: _____ **Client Date of Birth**: _____

****Please INITIAL each category that applies. Do not leave any space blank. Write N/A (not applicable)****

This certifies that I hereby authorize Tueller Counseling Services, Inc to:

_____ Release information to _____ Obtain information from _____ Exchange information with

Name of entity/person: _____ **Relationship**: _____
****Only 1 person/entity may be written here. Please fill out a different ROI for each person/entity****

Specific Information to be released:

_____ Dates of treatment
_____ Assessments/Evaluations
_____ Psychiatric and treatment record
_____ Progress and behaviors
_____ Health Connections Referral/History and Physical
_____ Treatment Planning
_____ Oral communication as needed
_____ Other as specified: _____

For the following purpose:

_____ Coordination of treatment/care _____ Academic considerations _____ Other: _____

In understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) Any revocations must be delivered in writing to each of the treatment providers listed above. I also understand that my records are protected under specific Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. Furthermore, I understand that Tueller Counseling Services, Inc. is released from all legal liabilities which may arise from the release of this information.

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****THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE****

Print Name: _____ Signature:_____ Date: _____

Refusal of Consent Signature: _____ Date: _____