Counseling Services PLLC

PATIENT PROFILE: School Based Therapy

DATE:_____ (Office Use Only: Provider):_____

NAME:_____
First Middle Last

ADDRESS:_____

COUNTY_____DATE OF BIRTH_____AGE_____ SSN#_____

MARITAL STATUS_____ DRIVER'S LICENSE #_____

HOME PHONE_____ WORK /CELL PHONE_____

LEGAL GUARDIAN/RELATIONSHIP_____

EMPLOYER OR SCHOOL ATTENDING/GRADE_____

EMERGENCY CONTACT/TELEPHONE_____

PRIMARY PHYSICIAN/TELEPHONE_____

CURRENT MEDICATIONS_____

ALLERGIES_____

NATURE OF CONCERN REQUIRING COUNSELING_____

_____

INSURANCE INFORMATION

TYPE OF INSURANCE:

Medicaid ☐ : ID Number:_____

Private Insurance ☐ : ID Number:_____

Non-insured ☐ : ID Number:_____

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Counseling Services PLLC

INFORMED CONSENT

By signing below, you acknowledge and are in agreement with our "**Informed Consent", "Client Rights and HIPAA Information" and "Financial Agreement".** We are happy to provide you a hard copy of our "**Informed Consent", "Client Rights and HIPAA Information"** and "**Financial Agreement**" at your request, or you may review these at www.jodiprovinceccs.com under "Client information/Forms." You also acknowledge that your therapists may use AI assisted notes in your documentation and are consenting acceptance to this model of documentation, including risks and benefits.

Agreement and Acknowledgement of our Informed Consent, Client Rights and HIPAA Information, Financial Agreement & AI assisted notes, as well as acknowledging our after-hours emergency policy with emergency contact numbers:

_____

Signature of Client or Guardian **Date**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/we consent that _____ (minor's name) may be treated as a client at JP Counseling Services, PLLC. Please be aware that the law may provide parents/guardians the right to examine treatment records. If is our policy to provide parents/guardians access to information about treatment. However, we also ask parents/guardians to trust us and allow us to keep your confidences on specific information and we will provide them with general information about your treatment sessions. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

_____

Signature of Client or Guardian **Date**

Your counselor's **professional disclosure statement** is located on jodiprovincecs.com, under the 'Counselors' section. By signing below, you acknowledge that you have read and understand this document.

_____

Signature of Client or Guardian **Date**

Counseling Services PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION: Doctor

I (We) authorize Jodi Province Counseling Services, PLLC to release and disclose information from the clinical record of:_____

Name of client/recipient of mental health services Date of birth

to, and allow such information to be inspected and copied by:_____

Facility/Provider/Address

Nature of information to be disclosed:_____

State specific nature of information to be disclosed

For the purposes of _____

State specific purpose of information to be disclosed

Information to be released and/or exchanged includes any available substance use/abuse or HIV/Infectious disease information as verified by client initials: yes_____ no_____

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Province Counseling Services, PLLC office. I understand that a revocation is not valid to the extent that Jodi Province Counseling Services, PLLC office has acted in reliance on such authorization. This authorization is valid 1 year from date of signature.

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

_____ _____

Client Signature 12 yrs. or older **Date** **Parent/Guardian Signature** **Date**

_____ _____

Witness **Date** **Relationship of Witness**

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Counseling Services PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION: SCHOOL SYSTEM

I (We) authorize Jodi Province Counseling Services, PLLC to release and disclose information from the clinical record of:_____

Name of client/recipient of mental health services Date of birth to, and allow such information to be inspected and copied by:_____

Facility/Provider/Address Nature of information to be disclosed:___**Recommendations to aid in school performance, diagnosis.**_____

State specific nature of information to be disclosed

For the purposes of ___**School-based therapy and coordination of care with school personnel for wrap around care**. _____

State specific purpose of information to be disclosed

Information to be released and/or exchanged includes any available substance use/abuse or HIV/Infectious disease information as verified by client initials: yes_____ no_____

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Province Counseling Services, PLLC office. I understand that a revocation is not valid to the extent that Jodi Province Counseling Services, PLLC office has acted in reliance on such authorization. This authorization is valid 1 year from date of signature

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

_____ _____

Client Signature 12 yrs. or older / Date **Date** **Parent/Guardian Signature**

_____ _____

Witness / Date **Guardian's Relationship to Client**

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for redisclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Counseling Services PLLC

Child/Adolescent Name: _____

TRAUMA SCREENING QUESTIONS: Place a check in the box for each type of trauma /loss experience that has occurred.
□ **Serious Accident**: Like a serious car, bus, train or bicycle accident or a bad fall where you or someone else was or could have been badly hurt or killed? OR have you ever witnessed a bad accident where someone was badly hurt or killed?
□ **Illness/Medical Trauma**: Have you ever been so sick that you or people taking care of you were scared that you might die? Did you have a medical concern that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?
□ **Community Violence**: Did you ever see a bad fight or shooting in your community? Were you afraid of getting badly hurt or killed? Have you seen someone robbed, stabbed, beaten up, or killed in your community?
□ **Domestic Violence**: Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?
□ **School Violence/Emergency**: Were you ever at school when something really scary happened, like a shooting, stabbing? Or were you or someone else got badly beaten up or someone attempted or committed suicide?
□ **Physical Assault/Abuse**: Have you ever been badly physically hurt (punched, kicked, stabbed) by someone outside of your family or who was not taking care of you?
□ **Disaster**: Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed?
□ **Sexual Abuse**: Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?
□ **Neglect**: Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?
□ **Psychological Maltreatment/Emotional Abuse**: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to or send you away?