ADULT CLIENT INFORMATION FORM

Client Information

Medicaid ID#:	APS ID#:	Date:	Intake Staff:

First Name: | Middle Name: | Last Name:

Age: | Date Of Birth: | Gender: ☐ Male ☐ Female | S.S.# | County:

Spouse Full Name: | Date Of Birth: | S.S.#:

Current Address: | Apt #

City: | State: | Zip Code:

Home Phone: | Fax: | Alternate: | Email Address:

Race: *(Choose only one)*
☐ Black/African American ☐ White/Caucasian ☐ Multiracial ☐ Asian
☐ American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Origin ☐ Yes ☐ No

Number of Individuals in Household:

Marital Status: ☐ Single Never married ☐ Separated ☐ Divorced ☐ Married ☐ Widowed

Monthly Household Income:

Payor/Funding Source: *(Present Document of Proof of Insurance, etc (card and/or policy #)*
☐ Self Pay ☐ Medicare ☐ Medicaid ☐ DJJ ☐ DFACS ☐ CMO ☐ Private Insurance
☐ State Contract Svcs. ☐ Medicaid Wavier ☐ If private, please specify:

At Risk of Homelessness
☐ Yes ☐ No

Insurance Information: Name of Primary Insurance Company:

Address: | State: | Zip: | City:

Phone No: | Group No: | Policy No:

Secondary Insurance Co: | Phone: | Policy/Group No:

Referral Source: (check all that apply)

☐ Self	☐ Family or Relative	☐ Access/Crisis Line	☐ Physician
☐ School	☐ Judge or Court	☐ Probation Officer	☐ Group Home
☐ DFACS	☐ DJJ	☐ State Hospital	☐ Law Enforcement
☐ Foster Home	☐ Concern Individual	☐ General Hospital	☐ Other (specify)

English Proficiency:
☐ Proficient ☐ Limited-Spanish Primary Language ☐ Limited - Primary Language Other

Communication: ☐ No Impairment Noted ☐ Single Words or Gestures ☐ American Sign Language ☐ Utilizes Language Technology

Special Population: ☐Vision Impairment ☐Hearing Impairment ☐Pregnant ☐Veteran ☐SSI/Disabled ☐ IV/Drug User ☐ HIV ☐ None

Living Situation: ☐ Private Residence ☐ Homeless Shelter ☐ Homeless not in Shelter ☐Residential Care ☐ Foster Home ☐ Jail/Correction Facility ☐Psychiatric Residential Treatment Facility (PRTF) ☐ Institutional Care/Nursing Home ☐Other:

Family History:	**Name**	**Age**	**Occupation**	**Lives in…(city/state)**
Father				
Mother				
Bros& Sisters				

Adult Education Level: ☐ 8th or under ☐ 9th – 12th ☐ H.S. Graduate ☐ Some College ☐ Associate ☐ Bachelor's Degree
☐ Master's Degree ☐ Doctorate ☐ Technical School ☐GED, If GED what year? ☐Other:

Legal Involvement: ☐ DFCAS ☐ Treatment Court ☐ Jail/Law Enforcement ☐ Parole
☐ Adult Probation ☐ Adult Criminal Court

Arrest: Number of arrests, regardless of nature of offense or outcomes, in the past 30 days:

Justice System Involvement: Has consumer been involved with criminal/justice system in the past year? ☐ Yes ☐ No If yes, include arrest, probation, parole, commitments, adjudications, diversions, or awaiting sentencing:____
Name of Probation Officer: Contact #:

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: | **Date Employed:**

Hourly or Weekly Wage: | **Name of Employer:** | **Weekly hours worked:**

What kind of problem brings you to Positive Growth Counseling Center?

How long has this problem persisted?

Under what condition do your problems get worse? / better?

Type of Substance(s) Used:	☐ None ☐ Alcohol ☐ Drugs ☐ Both		
Name of Substance(s) Used:	**Indicate the name of substances used/abused:**		
	Primary Substance Used	Secondary Substance Used	Tertiary Substance Used
Route of Administration:	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown	☐ Oral ☐Injection ☐Smoking ☐Other ☐Inhalation ☐Unknown
Frequency of Use:	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month	☐ Daily ☐ 1-2 times in the past week ☐ 3-6 times in the past week ☐ 1-3 times in the past month ☐ No use in the past month
Age at first use:			
Prior Treatment Episodes	How many previous treatment episodes has the consumer received in any drug or alcohol program?		
Tobacco Use(s)	How often do you smoke? ☐ Daily ☐ Once a Week ☐Two or more times week☐	At what age did you start smoking?	

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotion Abuse				Legal Problems			
Sexual Abuse				Multiple Family Move			
Physical Abuse				Homelessness			
Neglect Abuse				Military Family			
Family Violence				Discrimination			
Substance Abuse				Anger Issues			
Serious Illness				School Issues			
Accident or Injury				Gambling Issues			

(Do Not Write In This Section - This section will be completed with a Clinician)

☐ **SUICIDAL** ☐ **HOMICIDAL:** ☐ Plan ☐ Means ☐ **MENTAL HEALTH** ☐ **DRUG USE** ☐ **LEGAL** ☐ **Not Relevant**

Risk Assessment/Admission Priority:

☐ **HIGH RISK** (Emergent / Immediate-within 1 hour)
☐ Acute Illness – requires immediate hospitalization
☐ History of multiple psychiatric admissions
☐ Medications requiring frequent monitoring
☐ Suicidal or Homicidal
☐ Active substance abuse

☐ **MODERATE RISK** (Urgent / within 48 hours)
☐ History of psychiatric illness, but stable on medications
☐ No threat to self or others
☐ Substance abuse by history – no current usage

☐ **LOW RISK** (Routine / within 10 days)
☐ No previous psychiatric history
☐ No history of suicide attempts
☐ Diagnostic Impression/ No psychosis or severe mood disorder

Comments:

OVERALL RISK / PRIORITY: ☐ **HIGH** / Immediate ☐ **MODERATE** / <48 Hours ☐ **LOW** / < 10 days

Has the individual seeking services previously received Mental Health and/or Substance Abuse Services? ☐Yes ☐No
If yes, we whom:

Medications Current Medication: ☐ None ☐ Psychotropic ☐ Medical ☐ Other:

Does consumer follow medication regime? ☐ Yes ☐ No Prescribing Physician (indicate if PCP or Psychiatrist):

Name of Medication	Current Dosage/Frequency	Start Date	Side Effects
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Symptoms: (Please check all that currently apply. Those not checked are assumed absent).

☐ Depressed Mood ☐ Decreased Energy		☐ Disruption of Thought Process/Content		☐ Emotional/Physical/ Sexual Trauma Victim		☐ Emotional/Physical/ Sexual Trauma Perpetrator	☐ Concomitant Medical Condition
☐ Grief	☐ Hyperactivity	☐ Worthlessness	☐ Paranoia	☐ Hopelessness	☐ Anxiousness	☐ Elevated Mood	☐ Anger/Aggression
☐ Guilt	☐ Hallucinations	☐ Panic Attacks	☐ Delusions	☐ Impulsiveness	☐ Irritability	☐ Oppositional	☐ Obsession/Compulsion
☐ Shy	☐ Friendly	☐ Helpful	☐ Precise	☐ Shallow	☐ Outgoing	☐ Overweight	☐ Underweight
☐ Irritable	☐ Proud	☐ Weak	☐ Distant	☐ Low Self Esteem	☐ Lost	☐ Self Doubting	☐ Overwhelmed
☐ Sarcastic	☐ Hopeless	☐ Dependable	☐ Hopeful	☐ Tough Skinned	☐ Short Fused	☐ Defiant	☐ Poor Memory
☐ Guilty	☐ Passive	☐ Bizarre	☐ Grieving	☐ Empty	☐ Sad	☐ Distance	☐ Poor Concentration

EMERGENCY INFORMATION AND CONSENT FORM

Name:	**Record No:**	**Date: / /**
Address:	**Home PH:**	**Wk. PH:**
City:	**SS#:**	
State: Zip Code:	**Medicaid No:**	
Sex: D.O.B. : / /	**Medicare No:**	
Emergency Physician:	**Insurance No:**	
Attending Physician:	**Hospital Pref.:**	
Diagnosis:		
Allergies:		
Medications:		
In Case of Emergency Contact or Call:		
Guardian:	**Contact # 2:**	
Contact # 1:	**Contact # 3:**	

EMERGENCY CARE, CONSENT AND CONTACTS

In the case of a medical emergency while the client is participating in a program, the staff will provide first aid. In the event that the emergency room, hospitalization, or other appropriate medical or dental care is needed, appropriate transportation to the appropriate facility will be arranged. The parent/guardian/custodian (or designated contact person) will be contacted to meet the client at the facility. If the parent/guardian/custodian (or designated contact person) cannot be reached, the staff member may authorize the physician/dentist/facility to provide emergency treatment.

I, ____ (Client/Legally Responsible Person), authorize Positive Growth Counseling Center to contact the individual and/or physician I have indicated below in the event I become incapacitated due to emergency illness or accident while in treatment. This emergency contact consent will be in lieu of any other authorizations, if any, I have granted, or not granted to the below individual.

I also will hold harmless Positive Growth, Inc. and/or Counseling Center, staff, board of directors and other members against any liability caused by their taking of any emergency procedures and/or contacts. I agree to the Emergency Care Process as outlined above. I will assume the full responsibility of all incurred emergency treatment expenses.

I authorize Positive Growth, Inc. Counseling Center the holder of medical or other information about me to release any information necessary to process insurance claims, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to insurance assignment of benefits apply. I authorize Positive Growth, Inc. to provide, as necessary, to its contracted Qualified Service Organizations (e.g., laboratories, pharmacies, management information systems, billing and collection agencies) the following identifying information: my name, address, telephone number, date of birth, social security number, dates of service, and diagnostic code. This consent is valid until the above transactions related to my services are completed, not to exceed one year from the date below, unless and until I specifically revoke my consent to the release of any or all information at an earlier date.

I have read and understand the information regarding emergency contacts, emergency care and consent and the accounting of disclosure/release of information. All of the aforementioned forms have been explained to me.

I, ____ (Client/Legally Responsible Person) have received a copy of the Clients' Bill of Rights and confidentiality handout and each has been explained to me.

________________________________	___ /___ /___	__________________________	___ /___ /___
Client/Legally Responsible Person	Date	Employee Signature	Date

CONSENTS FORM

AGREEMENT TO PAY: I agree to pay the established fee of $_______ per session or the pay plan each month. **I understand that:**

- I may be denied an appointment and/or sent to Small Claims Court if I refuse to pay when I have the ability to pay.
- It is my responsibility to inform the agency of any changes, which affect the billing or charges to my account.
- I will be charged for a scheduled appointment if not canceled 24 hours in advance.
- We will bill your Insurance Co., CMO or Third Party for services rendered. We ask that you pay your co-pay before each session.
- If my insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement

ASSIGNMENT OF BENEFITS: I authorize payment by my insurance company or Medicare/Medicaid to be paid directly to Positive growth, Inc. Community Based Services for services rendered. I understand that I am financially responsible to Positive growth, Inc. Community Based Services for charges applied to the insurance deductible and for all charges limited by the insurance carrier.

CONSENTS FORM

CONSENT FOR SERVICES: Positive Growth provides services to individuals who have personal, social, emotional, developmental, and substance abuse problems. The staff members are trained to provide appropriate treatment as needed to help the individual. I/we present myself to receive services from Positive Growth, Inc. I/we understand that I have the right and responsibility to participate in all aspects of my plan for care. I/we can withdraw from services at any time. I/we consent to urine drug screens at any time during my treatment. If dissatisfied with decisions regarding my care, I/we can appeal those decisions or file a grievance. Information about me related to my services from Positive Growth, Inc. is confidential and may be privileged. This information is shared with staff involved in my care only on a need to know basis. It cannot be disclosed to a third party without my express consent except under special circumstances that include the following. Information about physical or sexual abuse, exploitation, neglect, or deprivation of a child or incapacitated adult will be reported as required by law. Positive Growth, Inc. will exercise its duty to warn other individuals if I/we threaten physical harm to them; if I/we threaten physical harm to me/other, the Agency will exercise its duty to care and will take reasonable steps to protect me. In the event of a medical emergency jeopardizing my life or health, Positive Growth, Inc. will disclose to my medical emergency care provider the information necessary to permit accurate diagnosis and treatment. When a court of legal jurisdiction issues a proper subpoena or order, the information specified may be submitted to a court of law. Limited information may be provided to law enforcement serving an arrest warrant or investigating a crime. Auditors, reviewers, evaluators, and consultants who are both recognized as legitimate by Positive Growth, Inc.'s Executive Director and are bound to protect confidentiality may obtain information directly related to the execution of their official duties.

I/we agree to treatment as offered by Positive Growth for:

☐ Myself ☐ My Spouse ☐ The person for whom I/we have power of attorney and/or guardianship

CLIENT RIGHTS AND RESPONSIBILITIES: I have received the client rights handout and the relevant handouts outlining my responsibilities as a client of Positive Growth Community Based Core Services program. I understand that it is my right to ask questions if I need clarification or have concerns.

CONFIDENTIALITY: In accordance with state and federal laws, information maintained about you at this agency will be protected from unauthorized disclosure. No information will be sent to your employer, family members, friends, or anyone else, unless it is discussed with you ahead of time and permission is obtained. Disclosure is permitted under state and federal laws for situations which may be applicable to you such as:

1. In the interest of public safety (life threatening situations)
2. In response to a court order
   Where state laws require that information be disclosed (e.g., suspected child or adult abuse, Communicable Disease)

Positive Growth Services requires reporting of non-identifying client information. This information is stored in a computerized record system for statistical, program planning, research, evaluation, and funding purposes.

Violation of the Federal and State laws and regulations by a program is a crime. Suspected violations may be reported to the U.S. Attorney in the district where the violation occurs.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary. I further acknowledge that I may revoke, in writing, this consent at any time except to the extent that action based on this consent has been taken.

RELEASE OF INFORMATION FOR PAYMENT: I hereby authorize Positive Growth, Inc. Counseling Center to release the necessary information from my record as requested to ____. This data will include dates of service, types of services, diagnosis, name of person providing services, and the relevant charges. Other information requested may also include any alcohol/drug or HIV/AIDS related treatment. This information will be used to process claims only.

ACKNOWLEDGEMENT OF CHILD ABUSE/NEGLECT REPORTING REQUIREMENT: All health and human service professionals are required by state law to report suspected abuse or neglect to the appropriate authorities. If you have any questions about this, please feel free to ask for a better understanding before you sign. Your signature below acknowledges receipt of this information.

PERMISSION FOR OFF-SITE ACTIVITIES: During the course of treatment, the client may on occasion, be off the premises attending therapeutic group outings. During these times, the client/parent/guardian agrees to release Positive growth, Inc. Counseling Center, Community Based Core Services Program from all liability and responsibility. Transportation will be provided by the program. This consent is valid until separation of client from the program or by written termination of permission by a parent/guardian/self.

________________________________	___/___/___	________________________________	___/___/___
Client/Legally Responsible Person	Date	Employee/Witness Signature	Date

Serving Children and Families
Since 1994

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize ____
(Facility/Provider)

____ to release
(Address)

Check (   ) all that are applicable to be disclosed:

___All materials in record
___Financial and Health Insurance
___Discharge Summary
___Probation and Legal Information
___Psycho-Educational Evaluation
___Medical history and treatment
___Progress notes and Treatment Plan
___Medication and treatment records
___Educational/School Records
___Psychiatric Evaluation
___Psychosocial history
___Juvenile Court Records
___Assessments and diagnosis
___Continuing Care Plans
___Psychological Evaluation

from the clinical record of____ (___________)
(Name of client/recipient of mental health services) (Date of birth)

to **POSITIVE GROWTH, INC. 3660 Market Street, Clarkston, Georgia 30021______________**

for the purposes of facilitating counseling/consultation, and/or conducting an evaluation. I understand that I may revoke this consent at any time. This authorization is valid until ________________.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _______ no information released and/or ______________________________
____.

A copy of this release shall have the same force and effect as the original.

_____________________________________ _________________________________
(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

________________________________ _____________________________
(Witness) (Date) (Relationship)

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.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) ____authorize **POSITIVE GROWTH, INC. 3660 Market Street, Clarkston, Georgia 30021.**

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)

Check ( ) all that are applicable to be disclosed:

___All materials in record	___Medical history and treatment	___Psychosocial history
___Financial and Health Insurance Date	___Progress notes and Treatment Plan	___Juvenile Court Records
___Discharge Summary	___Medication and treatment records	___ Assessments and diagnosis
___Summary of psychological testing	___Educational/School Records	___Only in emergency
___Psycho-Educational Evaluation	___Psychiatric Evaluation	___Psychological Evaluation

I understand that I may revoke this consent at any time. This authorization is valid until ____________.
(Date)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): _______ no information released and/or ___________________________
____.

A copy of this release shall have the same force and effect as the original.

______________________________________	______________________________________
(Client Signature 12 yrs. or older) (Date)	(Parent/Guardian Signature) (Date)
______________________________________	______________________________________
(Witness) (Date)	(Relationship)

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.

Consumer Rights

1. The right to agree to and approve of your treatment.
2. The right to be involved in planning your treatment.
3. The right to a written Individualized Service Plan (ISP) and be promptly and fully informed of any changes in the plan.
4. The right to have services provided in a way that fits your individual characteristics, needs, and abilities.
5. The right to review and obtain copies of your service record unless the physician or other determines it authorized staff not to be in your best interest.
6. The right to understand how to give permission to release or obtain information about your treatment, as well as how to revoke the permission.
7. The right to be free of physical abuse, sexual abuse, harassment or physical punishment.
8. The right to be treated with respect, dignity and kindness, free of mental abuse, such as humiliation, being threatened or taken advantage of.
9. The right to know funds are used for providing treatment instead of financial gain.
10. The rights to be informed of how to get other help you may need through referral to a) guardians or conservators, b) self-help groups, c) advocacy services, and d) legal services.
11. The right to be provided with information to help you make the best decisions.
12. The right to express who you want for a case manager, therapist, or other service provider.
13. The right to know how to use services when you are in a crisis.
14. The right to be free of any physical restraint or time-out procedure except for the purpose of providing effective treatment and protecting your safety and other persons.
15. The right to have and retain personal property, which does not jeopardize your safety or the safety of other consumers and have such property treated with respect.
16. The rights to written information that explains when the use of treatment interventions and restriction of rights would occur.
17. The right to know the limitations of confidentiality.
18. The right to privacy with respect to your past, present, and future mental health and medical information.
19. The right to receive treatment in the least restrictive environment available.
20. The right to refuse service, unless it is determined by a physician, licensed clinician or licensed psychologist that you are unable to care for self, is dangerous to yourself or others or is mandated by a court.
21. The right to receive clinically appropriate treatment even if it is determined you are unable to pay.
22. The right to be fully informed of the charges for treatment.
23. The right to obtain a copy of the program's most recently completed report of licensing inspections forms.
24. The right to request clarification if you have any questions regarding these rights.
25. The right of referral to legal entities for appropriate representation, and to self-help and advocacy support services.
26. The right to exercise all civil, political, personal, privacy and property rights to which you are entitled to as a citizen.
27. The right to remain free of psychological abuse, including humiliating, threatening, and exploiting actions.
28. The right to file a complaint if you think any of these rights have been restricted or denied. Information on how to file a complaint or contact your Consumer's Rights Representatives is presented on a poster near the reception desk at every service site.

Call or Write to: 404-657-5557. Office of Regulatory Services, ORS, Complaint Intake Unit, 2 Peachtree Street, Atlanta, GA 30303

404-657-7857. The Department of Behavioral Health & Development Disabilities, DBHDD.
2 Peachtree Street, Atlanta, GA 30303

I have reviewed these rights. I have received a copy of these rights and understand that a copy will be placed in my medical record.

Consumer Signature: ______________________________________ Date: ____________________

Parent/Guardian Signature: __________________________________ Date: ____________________