Community Alternatives, Inc.

NEW PATIENT INFORMATION FORM

Please complete all fields

Patient Name: _____ **DOB:** _____ **Social Sec #:** _____

Sex: _____ **Race:** _____ **Marital Status:** _____

Home Address: _____

City, State, Zip: _____ **Permission to mail to this address: Y or N**

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

Best Time to Call: _____ **OK to leave a message:** **Home:** Y N **Cell:** Y N **Work:** Y N

Parents Names or Legal Guardian (if minor): _____

For Minors: **Is there are current court order for custodial arrangements of your child?** ☐ **YES** ☐ **NO**

Emergency Contact Person: _____ **Relationship:** _____

Phone Number: _____

Primary Care Physician: _____

Primary Care Address/Phone Number: _____

Preferred Pharmacy: _____

Pharmacy Address/Phone Number: _____

Are you currently employed? ☐ **YES** ☐ **NO** **If yes, please answer the following:**

Employment Type: ☐ **Part Time** ☐ **Full Time** **Average # of Hours Worked:** _____

Employer: _____

Occupation: _____

Please Sign Back

Community Alternatives, Inc.

COMMUNITY ALTERNATIVES COUNSELING CENTER

CLIENT CONTRACT

Welcome to Community Alternatives Counseling Center

This document will describe the services you will receive, discuss our responsibilities for your care, as well as your responsibilities in the treatment process. The following policies are in place to help your experience with us to be a positive and effective one. If you have any further questions, please feel free to discuss them with your therapist.

Services Offered

Community Alternatives offers a wide range of treatment services. We offer one on one counseling, family and group therapy, as well as psychiatric services. Treating each person as an individual, we work closely with you in order to tailor services to meet your unique needs, utilizing some or all of our services.

The Intake Process

All clients entering the clinic will undergo a thorough, initial evaluation by a therapist. This process will take 1-2 sessions that must be completed within 15 days of your intake. Missing either of these sessions will result in discontinuation of services. You will be asked a wide range of questions from your medical history through your current situation. The therapist will evaluate and diagnose any conditions that may be contributing to current state. From there, the therapist will work with you to design a comprehensive treatment plan. If the therapist believes that counseling will be beneficial, the therapist will give the evaluation to the Clinical Director, who will assign you the therapist most qualified to work with you. The evaluation may also recommend psychiatric services. If psychiatric services are recommended, we will assist you in scheduling a psychiatric evaluation. Your assigned therapist will work closely with you and the Doctor throughout the treatment process.

Counseling

Counseling is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems that you bring. There are many different methods we may use to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things talked about during treatment both during the session and at home. Our clinic therapists have been trained in the "best practice" treatment interventions for a variety of mental health and/or behavioral concerns. Your active involvement requires a commitment and may include additional testing, homework and learning to be more independent of counseling services. Counseling can have benefits and risks. It has been shown to have benefits for people who go through it. It often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Since therapy often involves discussing unpleasant aspects of your life, you may also experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. But, there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to

continue with therapy. You should evaluate this information, along with your own opinions of whether you feel comfortable working with your therapist. Therapy works best if there is a good fit between the therapist and the client(s). Any time you have questions about your treatment or the services provided, please feel free to bring them up so that you and your therapist can discuss them. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Counseling typically involves one hour sessions, once per week, for 6 weeks to 9 months, depending on your condition and progress. Group sessions meeting weekly may also be beneficial, and we will recommend these when appropriate.

Psychiatric Services

If you are recommended for psychiatric assessment, you will be scheduled for an evaluation with the doctor. This evaluation usually lasts about 45 minutes. Your first initial appointment with the Doctor will take about 45 minutes – he may or may not prescribe medication on the first visit. If medication is prescribed on the first visit, the doctor will ask to see you back in 2 to 4 weeks, to complete a follow up visit to monitor your new medications. Thereafter, the doctor will see adults every 2-3 months, depending upon your medication and diagnosis. Children will be seen monthly for the duration of their treatment. Per clinic policy, your treatment plan must be updated at least every 90 days. If the Doctor and your therapist have determined that only medication management services are appropriate, you will continue to be scheduled with a clinic staff every 90 days in order to update your treatment plan.

It is important that you keep regular medication management appointments so that the doctor can monitor your physical and emotional stability face-to-face. It is also important that you see the doctor, so that you can discuss your concerns and well being.

Medication

Your health is important to us. Missed appointments and misuse of prescribed medication places your health at risk. Any misuse / abuse of medications prescribed by the doctor will result in termination of services. The clinic policy is to only provide medication at scheduled psychiatric appointments. It is your responsibility to attend all appointments and notify the doctor of any prescriptions that need to be renewed. Prescriptions will not be provided outside of your appointments. Due to the consequences of medication abuse, you will be asked to confirm that you are not receiving medication from any other medical provider.

Disability Evaluations

The clinic does not provide disability evaluations. We will, when requested by your attorney or the Bureau of Disability, provide documentation which can include your mental health and psychiatric evaluation. This documentation is provided for a fee as determined appropriate by the State of Pennsylvania.

Appointments

For the success of your treatment, it is imperative that you make all regular appointments with both your therapist and/or the doctor.

If you fail to attend your appointments on a regular basis, you will be discharged from our facility. If you do not show up for 2 appointments during the course of your treatment or cancel 3 or more appointments during any six month period, we will have to discontinue your services.

Hours
Both day and evening clinic hours are available. Evening hours are typically reserved for children who attend school during the day. Please discuss your scheduling needs with your therapist during the intake process. Group therapy is available on various evenings and is scheduled quarterly.

Clinic Hours for the New Castle office are as follows:
Monday, Thursday, and Friday: 9:00am – 5:00pm
Tuesday, Wednesday: 11:00am – 7:00pm

Clinical hours for the Bridgewater office are as follows:
Monday, Thursday, and Friday: 9:00am – 5:00pm
Tuesday, Wednesday: 11:00am – 7:00pm

During business hours, someone is usually available to discuss billing and scheduling issues. Your therapist will likely be working with other clients, and is not immediately available. Community Alternatives cannot provide counseling services over the phone.

Emergencies
If you are experiencing a medical emergency, please go to the emergency room.

Professional Records
The laws of standards of the counseling profession require that we keep treatment records. These treatment records typically include information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we developed for treatment, your progress toward these goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records and any reports that and send anyone including reports your insurance carrier. Except in unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your treatment records, if you request this in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the therapist's presence, or have them forwarded to another mental health professional so that you can discuss the contents with them. Clients will be charged an appropriate fee to any professional time spent in responding to information requests. It is our office's policy to destroy clients' records 10 years after the end of our therapy. Until then, we will keep your case records in a safe place.

Confidentiality
In general, the confidentiality of communications between a client and a therapist or psychiatrist is protected by law, and Community Alternatives can only release information about our work to others with your written permission. However, there are a few exceptions you should know.

In judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require us to testify if she/he determines that resolution of the issues before her/him demands it.

There are some situations in which we are legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment.

For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency. If we believe that a client is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm her/himself, we may be obligated to seek hospitalization for her/him or to contact family members or others who can help provide protection. Situations such as these are rare, but if such a situation occurs, we will make every effort to fully discuss it with you before taking any action.

Safety

Community Alternatives is committed to providing a safe treatment experience for its clients as well as a safe working environment for its employees. In order to do so we expect both clients and staff to treat each other with respect. Any verbal or physical threats of violence directed towards another client or a clinic employee will result in the immediate termination of treatment services. Physical assault will result in discharge and potentially the filing of criminal charges.

Payment for Services

Community Alternatives accepts most types of insurance. You will sign a financial responsibility form which explains your responsibilities for co-pays, co-insurance, and deductibles, as well as any services for which your insurer does not provide coverage. If you do not have insurance, you will be charged according to our fee schedule. A sliding scale is available for low-income clients. Fees are as follows:

Initial counseling session (Intake) $100.00
On-going counseling session $150.00
Psychiatric Evaluation$225.00
Psychiatric follow-up Appointment $80.00
Group Therapy $48.00

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to records. If they agree, we will provide them with general information about your treatment, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of these concerns. Your therapist will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you. We will do our best to handle any objections that you may have about what will be discussed.

_____ _____

Parent / Guardian Signature Date

_____ _____

Client Signature Date

Community Alternatives, Inc.

NAME: _____ DOB: _____

MEDICAL HISTORY

Have you ever been treated for any of the following: IF YES, PLEASE LIST HERE:

- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Circulation problems
- ☐ Diabetes
- ☐ Epilepsy, seizures, or convulsions
- ☐ Fainting spells, light-headedness, or dizziness
- ☐ Gastrointestinal problems
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Murmur or Disease
- ☐ Hepatitis, liver disease, or jaundice
- ☐ High blood pressure (hypertension)
- ☐ Other Infectious/Communicable diseases, Specify: _____
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Migraines
- ☐ Rheumatic fever
- ☐ Serious injury or accident
- ☐ Sleep disturbance, Describe: _____
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis (TB)
- ☐ Ulcer
- ☐ Uncontrolled bleeding
- ☐ Venereal Disease

Allergies
Please describe any allergies (include a description of your reaction)

ALLERGY	REACTION

Medication(s)
Please list any medication (prescription and/or over-the-counter) that you are currently taking (include reason, dosage, and prescribing physician).

MEDICATION	DOSAGE	REASON	PRESCRIBING PHYSICIAN

Have you experienced any of the following symptoms in the past 60 days? (Please indicate YES/NO)				
□ Ankle swelling	□ Coughing	□ Lightheadedness	□ Pulse Irregularity	□ Vaginal Discharge
□ Bed-wetting	□ Cramps	□ Memory Problems	□ Seizures	□ Vision Changes
□ Blood in stool	□ Diarrhea	□ Mole/Wart Changes	□ Shakiness	□ Vomiting
□ Breathing Difficulty	□ Dizziness	□ Nervousness	□ Sleep Problems	□ Other:
□ Chest Pain	□ Falling	□ Nosebleeds	□ Sweats (night)	
□ Confusion	□ Gait Unsteadiness	□ Numbness	□ Tingling in Arms & Legs	
□ Consciousness Loss	□ Hair Change	□ Panic Attacks	□ Tremor	
□ Constipation	□ Hearing Loss	□ Penile Discharge	□ Urination Difficulty	

Date of Last Physical Exam: _____

Medical Hospitalization/Surgical Procedures	
Have you had medical hospitalization(s) and/or surgical procedure(s)? ☐ YES ☐ NO If yes, please complete information below.	
DATE	**REASON**

If any hospitalizations in the last 6 months, how many emergency room episodes? _____

Physical Limitations List any physical limitations and/or needs.
☐ None
☐ Hearing, Describe:
☐ Sight, Describe:
☐ Speech, Describe:
☐ Mobility, Describe:

Describe current physical exercise program: _____

_____

_____

Community Alternatives, Inc.

Nutritional Screening (please check)			
☐ No problems	Eating: ☐ More ☐ Less ☐ Not Eating	Drinking: ☐ More ☐ Less ☐ Takes liquids only	Appetite: ☐ Increased ☐ Decreased
☐ Nausea	☐ Vomiting	☐ Trouble chewing or swallowing	
☐ Special Diet		☐ Other, please describe:	

Substance Use History/Current Use (Please check appropriate columns)											
Substance	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use
Alcohol/Beer/Wine	☐	☐	☐	Sleep Medication	☐	☐	☐	Cocaine/Crack	☐	☐	☐
Marijuana	☐	☐	☐	Tranquilizers	☐	☐	☐	Heroin	☐	☐	☐
Hashish	☐	☐	☐	Hallucinogens	☐	☐	☐	Pain Medication	☐	☐	☐
Stimulants	☐	☐	☐	Inhalants	☐	☐	☐	Other:	☐	☐	☐
Have you ever injected drugs or shared needles? ☐ YES ☐ NO											
Caffeine Use? If yes, form (coffee, tea, pop, etc.): ☐ YES ☐ NO				How much per week (cups, bottles)?							
Tobacco Use? If yes, form (cigarettes, cigars, smokeless): ☐ YES ☐ NO				How much per week (packs, etc.)?							

Print Name of Person Completing Questionnaire	Signature Name of Person Completing Questionnaire	Date

Community Alternatives, Inc.

NAME:_____
DOB:_____
ID #: _____

Financial Responsibility Agreement

for

Client Name (Please Print): _____

I understand and accept full financial responsibility for all services rendered by Community Alternatives, Inc., to me or to my dependent family member identified below. I understand that it is my responsibility to contact my insurance carrier regarding any coverage availability, and to supply my insurance carrier with all necessary documentation

I further agree to pay to Community Alternatives Inc., the co-pay, any additional amount owed beyond my insurance coverage, and any costs incurred for collection, or to pay cash for services when they are rendered.

Client/Parent/Legal Guardian Signature: _____ Date: _____

COMMERCIAL INSURANCE/MEDICAL ASSISTANCE

I hereby authorize release of information necessary to file a claim with my insurance carrier and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE AGENCY INDICATED ON THE CLAIM.

I understand the above financial policy and realize a copy of my signature is as valid as the original.

Client Signature: _____ Date: _____

Parent/Legal Guardian/Authorized Representative Signature: _____

MEDICARE

Name of Beneficiary (**Please Print**): _____ Medicare Number: _____

I request that payment of authorized Medicare Benefits be made on my behalf for any services furnished to me by Community Alternatives, Inc, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named agency any information regarding my Medicare claims under title XVIII of the Social Security Act.

Client Signature: _____ Date: _____

Parent/Legal Guardian/Authorized Representative Signature: _____