



CANCELLATION POLICY

Our therapists and physicians have a waiting list to see patients, due to this fact we must insist that you give us at least a 24-hour notice if in fact you need to cancel or reschedule an appointment. This allows us to try and fill the spot with a client that may be on our waiting list.

If we do not receive ample notification *prior* to your appointment, you will be charged \$45.

I acknowledge my financial responsibility if I do not comply with The Center for Counseling's Cancellation Policy.

Signature client/guardian

Date

Clinician

Date



CLIENT'S BILL OF RIGHTS

- Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.
- Each client has the right to accept or refuse all or part of his/her care and /or have the expected consequences explained.
- Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.
- Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
- Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.
- It is the right of each client to receive individualized treatment which includes:
 - Adequate and humane services regardless of the source of financial support.
 - Services provided in the least restrictive environment possible.
 - An individualized treatment plan which is reviewed periodically and as needed.
 - To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.
- If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency - they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
- The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
- The client will be informed of his/her rights in a language they can understand.
- Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources.
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

Recipients have rights protected by state and federal law and promulgated rules. For information contact:

Office Manager
50630 Chesterfield Road
Chesterfield Twp., MI 48051

or

Office of Substance Abuse Services
Recipient Rights Coordinator
PO Box 30035, 3500 North Logan
Lansing, MI 48909

The above Bills of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

Client/Guardian Signature

Date



50630 Chesterfield Road
Chesterfield Twp., MI 48051
Phone: 586.949.7680
Fax: 586.949.7681

Client's Name: _____ Phone #: _____

Address: _____
Street City State Zip

Your Therapist's Name is: _____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERGENCY: CALL 911

If you believe you are in danger or in imminent risk, suicidal or homicidal with intent: Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but transport to the emergency room right away.

BUSINESS HOURS:

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-949-7680. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = \$45, 30-60 minutes = \$90, and after 60 minutes, the charge will be \$1.00 per additional minute. _____

BEFORE/AFTER BUSINESS HOURS:

If an urgent matter arises which you would like to discuss with your clinician, **dial 1-586-949-7680** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100**. The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client / Guardian Signature:

Date:

Clinician Signature / Credentials

Date:



CONSENT FOR TREATMENT

I voluntarily consent to participate in the initial intake and assessment process.

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I understand:
 - a. that I may withdraw my consent in writing at any time.
 - b. that I must notify The Center for Counseling if my insurance carrier or coverage changes.
 - c. I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing The Center for Counseling in accordance with their regular rates. Any insurance balance not paid within 120 days will become my responsibility; The Center for Counseling will provide receipts so that I may turn them into insurance company.
 - d. Any and all balances will need to be paid off at the time of appointment. Next appointments can not be made until balances are paid.
 - e. That if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week. **If I fail to contact the office, I will be charged at the rate \$45 NO EXCEPTIONS!!** This fee is **not** billable to your insurance, and is due at the beginning of the next session. _____
 - f. Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filing fees, court costs, and reasonable attorney fees.
 - g. That I will be charged \$25 for any non-sufficient funds checks.
 - h. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.
 - i. That if I am a late cancellation or no call no show twice in a one year period my case will be closed.
 - j. That if my therapist or physician must write letters or fill out insurance forms there will be a \$75 charge for this service and that it takes up to a week to complete.
4. I have read and received a copy of the fire evacuation, fire drill procedure, tornado warning drill procedure and building map.
6. The Center for Counseling will use and disclose personal health information to treat you, to receive payment for the care we provide. We have prepared a detailed NOTICE OF PRIVACY PRACTICES BROCHURE to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notices in our office, on our web-site and have copies available for distribution. I have received a copy of the Notice of Privacy Practices.

 Client/Guardian Signature

 Date

 Clinician Signature

 Date



WELCOME

CLIENT INFORMATION

Client: _____ Date: _____
Last First
 Sex: ___ M ___ F Birth date: _____ Age: _____ Single Married Widow Separated Divorced
 SS#: _____ Address: _____
Street City Zip

PHONE NUMBERS

Home: _____ Cellular: _____
 Spouse's Name: _____ Alternate #: _____
 Whom may we contact in the case of an emergency? Name: _____
 Relationship: _____ Phone: _____ Alternate #: _____

INSURANCE INFORMATION

Who is responsible for this account? _____
 Relationship to Client: _____ Birthdate: _____ SS#: _____
 Insurance Co: _____ Contract #: _____ Group#: _____
 Is client covered by additional insurance? : ___ Yes ___ No
 Subscriber Name: _____ Phone: _____
 Relationship to Client: _____ Birthdate: _____ SS#: _____
 Insurance Co: _____ Contract #: _____ Group#: _____
 Whom may we thank for referring you to us? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Center for Counseling all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand it is my responsibility to pay any deductible amount, co-insurance, or any other balances not paid by y insurance company or pay the full client fee if I have no insurance coverage. Also, if The Center for Counseling is out-of-network, I am responsible for all charges. In the event that my insurance company does not pay within 120 days I am responsible for all charges and The Center for Counseling will provide receipts so that I may contact my insurance company. In the event that payment in full is not received within thirty(30) days, a service charge will be added to the outstanding balance, computed at the rate of one and a half (1.5%) percent per month. I hereby authorize The Center for Counseling to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

 Client/Guardian Signature Relationship Date



PERSONAL HISTORY FORM

MENTAL HEALTH SUBSTANCE ABUSE BOTH CLIENT ID #: _____

FORM COMPLETED BY (If someone other than client): _____

A. What brought you into treatment: _____

B. What are your expectations for treatment: _____

C. Prior treatment experiences (Dates and Location): _____

D. Name of Primary Care Physician: _____ Phone: _____

E. Current Living Arrangements:

1. House Group Living Apartment Other (specify): _____
2. Alone With Family Unrelated Significant Other

I. CLIENT INFORMATION (Past and present)

1. TREATMENT EXPERIENCES

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2. PRESENTING PROBLEM (Check all boxes that apply)

- | | |
|---|--|
| <input type="checkbox"/> Medical/Organic condition
<input type="checkbox"/> Depression
<input type="checkbox"/> Mania
<input type="checkbox"/> Chemical Abuse/Dependency
<input type="checkbox"/> Delusions/Hallucinations
<input type="checkbox"/> Family Issues
<input type="checkbox"/> Relationship Issues
<input type="checkbox"/> Other (please elaborate) _____ | <input type="checkbox"/> Anxiety
<input type="checkbox"/> Aggressive Behavior
<input type="checkbox"/> Suicidal Ideation's
<input type="checkbox"/> Self-destructive Behavior
<input type="checkbox"/> Anger
<input type="checkbox"/> Life Decision
<input type="checkbox"/> Uncertain |
|---|--|

3. SYMPTOMS

Any recent changes in:

	Yes	No		Yes	No
Sleeping Patterns	<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity Level	<input type="checkbox"/>	<input type="checkbox"/>
Eating Patterns	<input type="checkbox"/>	<input type="checkbox"/>	General Disposition	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Weight	<input type="checkbox"/>	<input type="checkbox"/>
Energy	<input type="checkbox"/>	<input type="checkbox"/>	Increased Tension	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please describe _____

Are you in physical pain? Yes No If yes, where and what kind: _____

If yes, please rate pain _____ 0 = none 5 = mild (tolerable) 10 = severe (referral)

THERAPY IMPLICATIONS: _____

II. INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS (Past and present)

1. FAMILY CONSTELLATION

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
			YES	NO	YES	NO
Client						
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others:						
(Brothers, Sisters, Grandparents, Step-relatives, Half-relatives)						
Specify Relationship						

2. FAMILY / EXTENDED FAMILY HISTORY

	Yes	No	Inpat-Outpt-IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3. FAMILY HISTORY

1. In what City/State were you born? _____
2. Where did you grow-up? _____
3. Who raised you as a child? _____

4. PARENTAL INFORMATION

- Parents legally married Mother remarried (number of times) _____
- Parents ever separated Father remarried (number of times) _____
- Parents ever divorced

Describe relationships with parents, step-parents

1. As a child _____

2. Currently _____

5. SIBLING INFORMATION

Number of living siblings/step-siblings _____ Number of deceased siblings/step-siblings _____

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe your relationships with siblings:

1. As a child _____

2. Currently _____

- Family will be involved in treatment
- Family uninvolved

Why/Why Not: _____

6. MARITAL INFORMATION

- Single Unmarried and living with significant other. Length of time _____
- Legally married - Length of time: _____ Total number of marriages: _____
- Separated - Length of time _____ Divorce in process: Yes No
- Divorced - Length of time _____ Widowed - Length of time _____

Are there problems in this relationship? (Check all that apply)

- Money Chemical Dependency Sexual Mental illness
- Physical Abuse Child rearing/discipline issues Religion Other

THERAPY IMPLICATIONS: _____

III. SOCIAL INFORMATION

1. SUPPORT SYSTEM (check all that apply)

- Adequate social support Recent move / relocation Conflict with peers
- Transportation problems Lack of knowledge of resources Isolative
- Problems establishing / maintaining relationships

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups):

THERAPY IMPLICATIONS: _____

2. SEXUALITY

What is your sexual preference Male Female Both Uncertain

Have you been tested for HIV Yes No

Are there sexual issues that you would like to discuss with your therapist? Yes No

Have you ever been sexually and/or physically abused? Yes No

THERAPY IMPLICATIONS: _____

3. INTERESTS/HOBBIES

Art _____ Book/Films _____ Music _____

Physical Fitness _____ Crafts _____ Outdoor Activity _____

Sports _____ Diet/Health _____

Current Memberships (church , clubs, organizations) _____

Do you participate in any cultural activities related to your ethnic background? Yes No

THERAPY IMPLICATIONS: _____

4. SPIRITUALITY

Do you believe in a god or a power greater than yourself? Yes No

What religion were you raised? _____

With what religion are you currently affiliated? _____

At this point in your life, what is most important to you? _____

THERAPY IMPLICATIONS: _____

IV. EDUCATION (check all that apply)

- High school diploma (GED) Currently enrolled: Last grade completed _____
- Did not complete high school: Last grade completed _____
- Vocational training - Training completed, type _____ Currently enrolled
- College: Degree earned, type _____ Currently enrolled
of years completed _____
- Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.) _____

THERAPY IMPLICATIONS: _____

V. EMPLOYMENT/VOCATIONAL

Beginning with most recent job, give employment history, include homemaker experience.

Employer	Dates	Job Description	Salary

THERAPY IMPLICATIONS: _____

VI. MILITARY

- Branch _____ Type of Discharge _____
- Date drafted/enlisted _____ Rank at Discharge _____
- Combat experience Yes No Date of Discharge _____
- Where _____ Where _____

THERAPY IMPLICATIONS: _____

VII. LEGAL DATA

Are you presently on probation or parole: Yes No

If yes reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): Yes No

If yes, please describe and indicate the court hearing/trial date _____

PAST HISTORY (adolescent and adult)

YES	NO	
		Traffic Violations
		Civil Involvement
		Criminal Involvement

If yes to any of the above, please complete the following:

Charges	Date	Where	Results

THERAPY IMPLICATIONS: _____

VIII. NUTRITIONAL ASSESSMENT

Please circle the answer or indicated number and total the score from both columns at the bottom.

Do you have an illness/condition that made you change the type/amount of food you eat?	Yes - 2	No
Do you eat at least two or more meals per day?	Yes	No - 3
Do you eat fruits or vegetables, or milk products every day?	Yes	No - 2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes - 2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes - 2	No
Do you always have enough money to buy the food you need?	Yes	No - 4
Do you eat alone most of the time?	Yes - 1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes - 1	No
Have you lost or gained 10 lbs. in the last six months?	Yes - 1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No - 2
TOTAL SCORE:		

0 - 2 = Low Risk 3 - 5 = Moderate Risk 6 - 21 = High Risk* * Referral

THERAPY IMPLICATIONS: _____

IX. ALCOHOL / SUBSTANCE ABUSE

Substance preferred _____

Date of last drink _____ Date of last drug use _____

Type and amount of drink at last episode Beer _____ oz. Wine _____ oz. Liquor _____ oz.

Age drinking/drug use began _____

Type of alcohol preferred: Beer Wine Liquor

How often do you drink/use drugs? Daily Weekly Monthly Other _____

Have you ever had any legal problems related to your use of alcohol/drugs? Yes No

Have you ever had any relationship problems related to your use of alcohol/drugs? Yes No

Has drinking or drug use ever become a problem? Yes No

If YES, please complete next page. (Substance Abuse Addendum)

If NO, go to page 10.

THERAPY IMPLICATIONS: _____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (Glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS: _____

II. ALCOHOL / DRUG RELATED PROBLEMS / BEHAVIOR / SYMPTOMS LIST

Please check all that apply.

PHYSICAL	EMOTIONAL	BEHAVIORAL
<input type="checkbox"/> Blackouts <input type="checkbox"/> Memory Problems <input type="checkbox"/> Tremors / Shakes <input type="checkbox"/> Seizures <input type="checkbox"/> DT's <input type="checkbox"/> Hallucinations <input type="checkbox"/> Overdose <input type="checkbox"/> Appetite Problems <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Injury <input type="checkbox"/> Accidents <input type="checkbox"/> Other Medical Problems <input type="checkbox"/> Other	<input type="checkbox"/> Depression <input type="checkbox"/> Confusion <input type="checkbox"/> Concentration Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability / Restlessness <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Mood Swings <input type="checkbox"/> Impulsivity <input type="checkbox"/> Euphoria <input type="checkbox"/> Relaxation <input type="checkbox"/> Extreme Jealousy <input type="checkbox"/> Paranoia <input type="checkbox"/> Feelings of Guilt/ Shame <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Other	<input type="checkbox"/> A.M. Use <input type="checkbox"/> Sneaking <input type="checkbox"/> Gulping <input type="checkbox"/> Loss of Control <input type="checkbox"/> Relief Use <input type="checkbox"/> Impulsive Use <input type="checkbox"/> Use less than before <input type="checkbox"/> Use more than before <input type="checkbox"/> Use despite negative Consequences <input type="checkbox"/> Associate with using friends <input type="checkbox"/> Plan activities around use <input type="checkbox"/> Loss of interest in activities <input type="checkbox"/> Change in work/school performance <input type="checkbox"/> Work/school lateness/ absenteeism <input type="checkbox"/> Job loss due to use <input type="checkbox"/> Frequent arguments <input type="checkbox"/> Separation/divorce <input type="checkbox"/> Financial problems <input type="checkbox"/> Legal problems <input type="checkbox"/> Physically abusive to self <input type="checkbox"/> Physically abusive to others <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Homicide attempts <input type="checkbox"/> Other

If any of the above are checked off, please describe: _____

III. SUBSTANCE ABUSE FAMILY HISTORY

Please describe the alcohol/drug problems of others in your family, past and present.
 Also describe treatment and recovery experience.

WHO / RELATIOINSHIP	PROBLEM TYPE	TREATMENT RECOVERY

IV. MEDICAL INFORMATION (past and present)

1. RECENT TREATMENT HISTORY

	DATE	REASON	RESULTS
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

2. REVIEW OF PAST/PRESENT CONDITIONS

Please check any of the following medical problems you have, or have had in the past:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Adrenal problems | <input type="checkbox"/> Head Injury/Loss of Consciousness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Allergies | |

If yes to any of the above, please describe and give dates: _____

3. CURRENT MEDICAL SYMPTOMS/PROBLEMS: Please check all that pertain to you now:

EYES:

- Double Vision
- Eye Pain
- Problems with Vision

EARS:

- Hearing Aid
- Buzzing/Ringing in ears
- Infection in ears
- Problems with balancing
- Problems with hearing

NOSE:

- Nose bleeds
- Stuffy nose

MOUTH:

- Loss of taste
- Problems with teeth
- Dentures

RESPIRATORY:

- Shortness of breath
- Chronic cough
- Sputum/mucus production
- Positive TB test
- Coughing up blood

SKIN/JOINT/MUSCLE

- Changes in skin
- Changes in nails
- Changes in hair
- Skin rash
- Skin itchy/dry
- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

GASTROINTESTINAL:

- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Black tarry stool
- Abdominal pain

GENITO/URINARY:

- Pain/burning with urination
- Frequent urination at night
- Bloody/brown urine
- Difficulty starting urine flow
- Constant need to urinate

NERVOUS SYSTEM:

- Headaches
- Numbness
- Fainting spells
- Convulsions/seizures
- Memory problems
- Coordination problems
- Tremors/shakes
- Loss of movement
- Loss of sensation

GENERAL HEALTH:

- Overweight
- Underweight
- Chills
- Fever
- Tire easily
- Night/day sweats

CARDIOVASCULAR:

- High blood pressure
- Low blood pressure
- Heart skips a beat
- Palpitations
- Fast heart rate
- Chest pains
- Swollen ankles

FEMALES ONLY:

- Menstrual irregularities
- Menopause
- Problem pregnancy
- Miscarriage #: _____
- Abortion #: _____
- Premenstrual problems
- Infertility
- Currently pregnant

If you checked any of the above, please describe: _____

4. MEDICATION AND DRUG USE Include prescription, non-prescription, and illegal drugs.

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Any history of drug overdose: Yes No If yes, please describe: _____

Any medication allergies? Yes No If yes, please describe: _____

Do you believe you would benefit from any of the following?

- Anger Management Education Series
- Substance Abuse Education Series
- Grief Group

STAFF USE ONLY

Yes No N/A

Client currently being treated by Primary Care Physician for symptoms checked on page 10

Yes No

Referred for physical

CLINICIAN SIGNATURE/CREDENTIALS

DATE

PSYCHOLOGIST SIGNATURE

DATE

Physician Agrees Disagrees with referral

If disagree reason _____

PHYSICIAN SIGNATURE

DATE

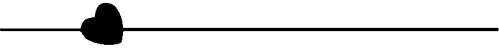
Notice of Privacy Policies and Practices

Our promise to you on the privacy of your health information

The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for the purpose of providing you with quality mental health and substance abuse care.
- Your private healthcare information may be released to your insurance company for the purpose of The Center for Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by the agency to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The agency is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- The agency will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the agency: The Center for Counseling, ATTN: Office Manager, 50630 Chesterfield Road, Chesterfield Twp., MI 48051.

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency. For further information about this Privacy Notice, please call us at 586.949.7680.



The Center for Counseling
Your Life Is Precious.SM

Dear Client,

Welcome to The Center for Counseling. We strive to serve our community in all of its mental health needs. Please note that this includes sharing our annual goals with our clients. Our goals this year are as follows:

- 1.Hire an additional addiction therapist.
- 2.Hire a therapist specializing in Autism/Aspergers.
- 3.Become a MESSA insurance provider.
- 4.Increase of sessions by 10%.
- 5.Increase group therapy to at least 3 running weekly.
- 6.Remain financially stable.

Thank you for choosing The Center for Counseling for your mental health needs. Please let us know if there is any way we can assist you further.

Sincerely,

Center for Counseling Staff