



Teen Client Information

Client's Name (First MI Last):

Preferred Name or Nickname:

Date of Birth:

Age:

Gender:

Parent/Caregiver 1	Parent/Caregiver 2
Name:	Name:
<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian <input type="checkbox"/> Other:	<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Guardian <input type="checkbox"/> Other:
Mailing Address:	Mailing Address:
Physical Address:	Physical Address:

Please DO NOT list any numbers where you would prefer not to receive calls or messages.

Home:	Home:
Cell:	Cell:
Work:	Work:
Email:	Email:
<small>Check this box to receive email communication from Counseling Associates</small> <input type="checkbox"/>	<small>Check this box to receive email communication from Counseling Associates</small> <input type="checkbox"/>

As a courtesy, we offer the option of appointment reminders by email, text, or landline phone message. These messages are delivered 48-hours in advance. These serve as reminders only and should not be relied upon exclusively. Please also be sure to note your appointment in your own personal calendar.

Would you like to receive optional courtesy reminders? Yes No

Requested Method: Email Text Landline Phone Message *(select one only)*

Insurance Information

Primary Insurance Company:	Secondary Insurance Company:
ID#:	ID#:
Group #:	Group #:

Please provide your insurance card(s) for copying at the time of appointment or upload a photo of the front and back of your card(s) via our secure portal on ca-mh.com.

Payment Authorization

Type of Credit Card:	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> AMEX
Name on Card:	eSignature:
Card Number:	
Expiration Date:	Security Code (CVV):
Street or P.O. Box Number :	Zip Code:

Options: Use for my co-payment for each session
Check all that apply Use only when I call to give authorization
 Use for any balance for which I am responsible
 Use for balances on late cancellations or missed sessions

Special Instructions:



Financial Agreement

I understand and agree that Counseling Associates of New London, PLLC (offices including New London, Newport, Claremont, the Upper Valley, Hanover, and Plymouth), **requires payment at the time of service.** I understand that I have the option to leave a credit card on file to cover these charges. I understand that if I choose not to leave a credit card on file, after 2 visits of non-payment, my services may be suspended until my balance is paid in full. Payments can be made by check, cash, or credit card.

I understand that I am financially responsible for any and all costs associated with services which are considered part of my deductible, co-payment, and/or co-insurance stated by my insurance, and services my behavioral health insurance does not cover.

I understand that I am responsible for notifying Counseling Associates of any insurance changes. If I do not notify Counseling Associates of New London, PLLC, I will be responsible for paying in full any charges incurred for services provided that are not able to be billed to my new insurance company. Counseling Associates has 30 days to submit all claims to insurance. If they are not submitted within 30 days, insurance may not pay for the services. Services will be charged \$180 to \$365 per session, depending on the service, for any visits that are not covered by insurance.

Appointment Cancellation Policy: We have a standard 24-hour cancellation policy and \$60.00 missed session fee. Please notify us of cancellation at least 24 hours prior to your appointment to avoid the \$60.00 fee. Missed sessions cannot be charged to insurance.

Signature

Date

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your child's primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your child's PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

I authorize coordination of care between my child's PCP and Counseling Associates. *Please sign release on following page.*

I decline coordination of care at this time. *Do not complete release on following page.*

I have questions about coordination of care and would like to wait and speak with my child's therapist.

My child has other providers or individuals for whom I would like to authorize communications. *Please sign release on following page*

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering for my child. I have had all of my questions answered to my satisfaction. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my child's treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my child's therapist's control. (e.g. if my child's treatment has been court-ordered. I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering for my child, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, the Upper Valley, Hanover, and Plymouth. I consent for my child to receive services from Counseling Associates and I agree to take an active role in my child's treatment.

Signature of Parent/Guardian

Date

Printed name

Relationship to client

Signature of Provider

Date



Please Tell Us

In a sentence or two, please describe the reason for the appointment:

What do you hope to gain from therapy?

What strengths do you have that you will bring to this work?

Have you seen a therapist before? Yes No

If Yes, please note the name of the therapist(s) and approximate date(s):

Health Information

Primary Care Provider:

Date of Last Physical:

Other Providers:

Current Health: Good Fair Poor

Are you concerned about your health? Yes No

Allergies:

No Known Drug Allergies

Current Medications

Medication	Dosage	Medication	Dosage

Please attach additional sheet(s) as needed for additional medication information.



Authorization to Disclose Health Information

_____, born on this date _____
(Name of person whose information is being disclosed)

authorize **Counseling Associates of New London, NPLLC** to

Release Receive Exchange

Protected Health Information (PHI) about the above referenced individual to:

Name: _____ Phone: _____

Address: _____

Information as described below:

Category of Protected Health Information: I authorize the disclosure of information from the following categories of protected health information (check those that are applicable):

Mental Health (MH) Substance Use Disorder (SUD) Both (MH/SUD)

Type of Information / Record: Check the information / record type you wish disclosed

Check **Yes** if you request the **Entire Record** to be disclosed - *this includes, but is not limited to:*
assessment, treatment plans, progress notes, medication, attendance, test results,
behavioral support plans, discharge reports, etc.

Check **No** if you wish to specify which of the items below to disclose:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attendance
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Assessments/Evaluations including diagnosis, treatment recommendations
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Treatment Plan/Individual Plan of Care
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Progress Notes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medications Prescribed
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Agency Discharge Summary/Plan
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Behavioral Support Plans
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Test Results (includes lab results and urine toxicology reports)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (must specify):

Date range of information to be disclosed: _____

The purpose of the disclosure: _____

Date or event upon which this authorization will expire: _____

I understand that if I do not note a date or event, this authorization will expire one year from the date signed below.

If none is indicated the means of this disclosure may be written, verbal, or electronic.

- I understand that my substance use disorder treatment records are protected under federal regulations, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise allowed by the regulations or required by law.
- I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, protect all of my healthcare records and may only be disclosed as permitted by the regulations or with my authorization.
- For disclosures of information made to organizations outside of the State of New Hampshire, health information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Standard of HIPAA.
- I understand that confidentiality of such records is also protected by State law.
- I understand that generally Counseling Associates may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied participation in the services if I do not sign an authorization form.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment payment or healthcare operations.
- I also understand I will not be denied services if I refuse to authorize a disclosure for other purposes.
- I understand that I may request restrictions on the use or disclosure of information for the purposes of treatment, payment, and healthcare operations that Counseling Associates may or may not agree to the requested restrictions.
- I understand I may revoke this authorization at any time except to the extent that the practice or other agency making the disclosure has already acted in reliance on it. In general, revocation should be submitted in writing and sent to the practice at our address.

I have read all of the above information and I understand its content and authorize the disclosure of confidential information identified above to the party listed above.

Name of Client (please print)

Date

Signature of Parent/Guardian

Date

Substance Use (To be completed by Client)

How often do you have drinks containing alcohol?

- 4+x/week
 2-3x/week
 2-4x/month
 monthly or less
 never

How many drinks containing alcohol do you have in a typical day?

Do you use tobacco?

How much?

Other substances used:

Frequency:

Are you concerned about your alcohol, tobacco, or other substance use?

Physical Health Issues:

Mental Health or Substance Use Treatment History, including hospitalizations:

History of self-harm? Yes or No

History of trauma, abuse, or violence? Yes or No

Substance Use, *Continued* (To be completed by Client)

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you.

<i>During the last 6 months...</i>	Yes	No
Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, marijuana, cocaine, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt that you use too much alcohol or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tried to cut down or quit drinking or using alcohol or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, counselors, or a treatment program)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any health problems? <i>For example, have you:</i>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Had blackouts or other periods of memory loss		
<input type="checkbox"/> Injured your head after drinking or using drugs		
<input type="checkbox"/> Had convulsions, delirium tremens ("DTs")?		
<input type="checkbox"/> Had hepatitis or other liver problems?		
<input type="checkbox"/> Felt sick, shaky, or depressed when you stopped?		
<input type="checkbox"/> Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?		
<input type="checkbox"/> Been injured after drinking or using?		
<input type="checkbox"/> Use needles to shoot drugs?		
Has drinking or other drug use caused problems between you and your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>
Has your drinking or other drug use caused problems at school or at work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you needing to drink or use drugs more and more to get the effect you want?	<input type="checkbox"/>	<input type="checkbox"/>
Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
When drinking or using drugs, are you more likely to do something you wouldn't normally do? (Such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone)	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a drinking or other drug problem?	<input type="checkbox"/>	<input type="checkbox"/>
The next questions are about your lifetime experiences:	Yes	No
Have any of your family members ever had a drinking or drug problem?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you have a drinking or drug problem now?	<input type="checkbox"/>	<input type="checkbox"/>



Comprehensive Core Standardized Assessment (Child/Minor)

Name:

DOB:

PCP:

PCP Phone:

Office Location: New London Upper Valley Newport Claremont

1. Do you ever need help reading or understanding your child's health information? Yes No
2. Does your child currently use tobacco products? Yes No
3. Do you or your family currently have any legal issues that interfere with your child's healthcare? Yes No
4. What is your family's housing situation today?
- We don't have housing (couch surfing, motel, on the street, vehicle, abandoned building or a homeless shelter)
 - We have housing today, but I'm worried we might lose it in the next 90 days
 - We have housing that is safe and adequate
5. In your child's housing situation, do you have issues with any of the following?
- Lead paint or pipes Bug infestation Mold
 - Oven or stove does not work No smoke detector/detectors do not work
 - Other: _____ None
6. How hard is it for you to pay for your family's basic needs of food, housing, heat, or medical care?
- Not hard at all Somewhat hard Very hard
- If **Somewhat hard** or **Very hard**, what do you have trouble paying for? *(Check all that apply)*
- Food Health Needs Utility bills (electric, oil, propane, etc.)
 - Housing Childcare Debts Other: _____
7. Does your child need assistance with any of the following tasks?
- Bathing Getting in or out of chairs Grooming Dressing
 - Walking Eating Using the toilet No, I do not have difficulty with these activities
8. Does your child have someone they could call for help or a favor? Yes No
9. In the last 12 months, has your child or anyone in your household been threatened or abused physically, emotionally, or sexually by a partner, spouse, or family member? Yes No
10. Do you have any concerns related to your child's health? Yes No

Patient Health Questionnaire (To be completed by Client)

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems:

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Column Totals: ____ + ____ + ____ + ____

Total Score: _____

General Anxiety Disorder Screening (To be completed by Client)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems:

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Being so restless that it is hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Feeling afraid, as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Column Totals: ____ + ____ + ____ + ____

Total Score: _____