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:
☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:	☐ Biological ☐ Adoptive ☐ Guardian ☐ Other:
Mailing Address:	Mailing Address (if different from Parent 1)
Physical Address, if different:	Physical Address, if different:
Contact Information	Contact Information
***Please DO NOT list any numbers where you would prefer not to receive calls or messages.**	***Please DO NOT list any numbers where you would prefer not to receive calls or messages.**
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:

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 & should not be relied upon exclusively. ***Please also be sure to note your appointment in your own personal calendars****.*

Would you like to receive optional courtesy reminders? ☐ Yes or ☐ No

Requested Method: ☐ Email ☐ Text Message or ☐ Landline Phone Message (select one choice only)

Client Referred By:

Financial Information

I understand that I am responsible for charges incurred that are not covered by my insurance and that I am responsible for understanding my coverage and for knowing when the limits of my coverage are being exceeded. I authorize the release of information necessary to file a claim with my insurance company, including electronically, and assign benefits to Counseling Associates of New London, PLLC, Counseling Associates of Newport, Counseling Associates of Claremont & and Counseling Associates of The Upper Valley. A copy of this signature is as valid as the original.

Signature:	Date:
Primary Insurance Company:	Secondary Insurance Company:

Please provide the insurance card(s) for copying at the time of appointment.

Responsible party to whom statements will be sent if different from Client:

Address:

Phone:	Relationship:

Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with the primary care provider 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 the primary care provider (PCP), Counseling Associates will send a confirmation to the 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, by phone or by secure electronic means. We are happy to answer any questions you may have about coordination of care and this authorization.

☐ I authorize coordination of care between the (PCP) and Counseling Associates. ***Please sign release on next page.***
☐ I decline coordination of care at this time. ***Do not complete form on the following page.***

☐ I have questions about coordination of care and would like to wait and speak with my therapist.
☐ I have other providers or individuals for whom I would like to authorize communication.

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the **Information for Clients** brochure (available on the website or in office) that includes:

- **Counseling Associates Practice Information**
- **CA Cancellation Policy**
- **Notification of Privacy Policies Regarding Protected Health Information (PHI)**
- **NH Mental Health Bill of Rights**

I understand the information about the therapy I am considering for my child. I have had all 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 treatment with this therapist at any time. I understand that I will still be responsible for paying for the services that have already received. I understand that there may be consequences to such a decision outside of the therapist's control (e.g. if my 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 my professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont & the Upper Valley. I consent to receive services from Counseling Associates & I agree to take an active role in my own treatment.

Signature of client (or person acting for client)	Date
Printed name	Relationship to client
Signature of Provider	Date

Counseling Associates

(603) 865-1321
fax: (603) 865-1327
ca-mh.com

Authorization for Release of Protected Health Information & Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. I am authorizing Counseling Associates to exchange Protected Health Information with my teen's care team.

➔ Client Name: ____ DOB: _______________

➔ Primary Care Provider: __________________________________ Address/Practice: _________________________

I authorize exchange of information for the purpose of coordination of care. This release permits such exchange for all dates of service unless specified below. I understand that unless another date or event is specified below, this authorization will expire one year from the date it was signed below. I am authorizing sharing of information verbally, in writing, and through secure electronic means.

➔ Please note any specification or limitations to the above:

I understand that in authorizing release of information from Counseling Associates, I am authorizing release of Mental Health Records or records related (e.g. billing information). Additionally, to the extent the record contains information about any of the following, I hereby expressly grant authorization to exchange such information:
Please initial: HIV test results ______ Genetic Testing______ **or** Substance Use records (prognosis, diagnosis, or treatment records of patient for drug or alcohol abuse protected by Federal confidentiality rules (42 CFR part2)) ________.

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- I understand that I may revoke this authorization in writing at any time by notifying Counseling Associates except to the extent that action has been taken in reliance on this authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Revocation will be effective as of the date received.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or State privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

____ _______________________________
Signature of Client/ Parent/ Legal Guardian Date

____ _______________________________
Printed name of personal representative Legal authority of personal representative

____ _______________________________
Witness Date

Information

In a sentence or two, please describe the reason for the appointment.
What do you hope gain from therapy?
What strengths does your teen have?
Has your teen seen a therapist before? ☐ Yes or ☐ No If yes, please note the name of therapists and approximate dates.

Health Information

Primary Care Provider:		Date of Last Physical:	
Other Providers:			
Current Health: ☐Good ☐Fair ☐Poor		Are you concerned about your teen's health? ☐Yes or ☐No	
Allergies:		☐ No Known Drug Allergies	
Current Medications			
Medication	Dosage	Medication	Dosage
**Please attach additional sheet(s) as needed for additional medications.*			
Substance Use			
Are you or your teen concerned about their ☐ alcohol, ☐ tobacco, or ☐ other substance use?			
Physical Health Issues:			
Mental Health or Substance Abuse Treatment History, including hospitalizations:			
History of self-harm? ☐ Yes or ☐ No			
History of trauma, abuse or violence? ☐ Yes or ☐ No			
School successes and concerns:			