Crossroads Counseling Center
300 Main St. Suite 230, Dubuque, IA 52001
Phone: (563) 556-0699 Fax: (563) 583-3077
E-mail: info@crossroadsdbq.com

Welcome to the Crossroads Counseling Center. The questions on the following pages are designed to help best meet your treatment needs. If you have any questions, please contact Crossroads.

## DEMOGRAPHIC INFORMATION

Client Name _____ Birth Date: _____

Gender: _____ Email Address: _____

Legal Gender (if different than above)_____

## CONTACT INFORMATION

Address: _____ City, State, Zip: _____

Home Phone: (_____) _____ Work Phone (_____) _____

Cell Phone: (_____) _____ Other Phone (_____) _____

Emergency Contact: _____Relationship to Client: _____Phone: (_____) _____

## INSURANCE & MEDICAL INFORMATION * THIS INFORMATION MUST BE PROVIDED*

| Primary Insurance Information | Secondary Insurance Information |
|---|---|
| Insurance Company: | Insurance Company: |
| Insurance Address: | Insurance Address: |
| Ins. City/State/Zip: | Ins. City/State/Zip: |
| Subscriber' Name: | Subscriber' Name: |
| Subscribers DOB: | Subscribers DOB: |
| Employer: | Employer: |
| Employer Phone #: | Employer Phone #: |
| Subscriber ID: | Subscriber ID: |
| Policy #: | Policy #: |
| Group #: | Group #: |
| Subscriber's Relationship to Client: ☐ Parent ☐ Spouse ☐ Other: | Subscriber's Relationship to Client: ☐ Parent ☐ Spouse ☐ Other: |

## REFERRAL AND COLLATERAL INFORMATION

Referral Source: _____

If you would like your counselor to coordinate treatment with your primary physician please fill out the following information and request to sign an Authorization to Release Information form.

Primary Care M.D.: _____ Phone #: _____

Other Therapist: _____ Phone #: _____

☐ May not release information. Reason: _____

## ASSESSMENT AND NEEDS

1. Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment, please list the event:

   _____

   _____

   _____

2. Have you ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:_____

   _____

3. Have you ever been the victim of emotional, physical, sexual abuse or been witness to domestic violence/abuse? ☐ Yes ☐ No Explain: _____

4. Please list any medications you are currently taking (including dosage and prescriber):

   _____

   _____

5. Do you suffer from depression? ☐ Yes ☐ No Scale (circle one): 1 2 3 4 5 6 7 8 9 10 (1 low, 10 high)

6. Have you had **current or previous** suicidal ideations, thoughts, or attempts? ☐ Yes ☐ No

   Explain: _____

7. Do you suffer from anxiety? ☐ Yes ☐ No Scale (circle one): 1 2 3 4 5 6 7 8 9 10 (1 low, 10 high)

8. Any traumatic events in your life? ☐ Yes ☐ No Explain when, how, and what? _____

   _____

   _____

9. Any psychosis symptoms or behaviors? ☐ Yes ☐ No Explain: _____

   _____

## TREATMENT PHILOSOPHY

The professional staff at Crossroads Counseling Center believes in providing goal-directed treatment. If you ever have any questions about the nature of the treatment of anything else about your care, please do not hesitate to ask.

## CONFIDENTIALITY

All information between provider and client is held strictly confidential unless:

1. The client authorizes release of information with his/her signature, or if client is a minor the parent/guardian signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect is suspect.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

## FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed. You will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for full payment.

## CANCELLED/MISSED APPOINTMENTS

If an appointment is missed or cancelled with less than twenty-four (24) hours notice, you may be billed $50 for the missed appointment.

## EMERGENCY PROCEDURES

If you need to contact your counselor, leave a message according to the instructions on the phone service (556-0699) and your call will be returned. If an emergency situation arises, call the crisis phones or go to the Emergency Room.

## RELEASE OF INFORMATION

By signing below, you authorize the release of information regarding your care to your health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for your health plan while being seen at Crossroads.

## OFFICE HOURS

The Crossroads Counseling Center staff is dedicated to meeting each client's scheduling needs. Each staff member maintains their own working hours. Please check with your counselor for their available times. Crossroads Counseling Center is closed on all major holidays unless exceptions are made by your counselor.

## CONSENT FOR TREATMENT

Please read the following statement and sign below:

I authorize and request that the professional staff at the Crossroads Counseling Center carry out mental health examinations, therapy, counseling, evaluations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I hereby acknowledge that I am willing and without coercion, taking part in these mental health related procedures.

*By signing below, I understand and agree to the above information:*

_____ _____

Client Name – Signature Date

# BILL OF RIGHTS

1. Each client shall have reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.

2. Each client has the right to privacy, confidentiality, and security, in accordance with agency, state and federal regulations governing the confidentiality of information. Client confidentiality will be maintained during case consultations, clinical supervision and all internal or external audits of clinical records. All records reviewed by auditors, external entities and business associations, will be noted on the accounting summary form for HIPAA purposes.

3. Each client who seeks services voluntarily has the right to refuse and/or terminate care, treatment or services at any time.

4. Each client has the right to express comments or complaints about any aspect of the care, treatment and service process without being subjected to coercion, discrimination, reprisal or unreasonable interruption of care, treatment or services. The client may express concerns through informal discussions or through the formal grievance procedure. Family and legal guardians have the right to file the grievance as well.

5. Treatment goals and therapy modes can change over time. For example, we may begin with individual therapy and work towards family therapy. While working individually with a child, we may meet with the parent individually to work on how to best work towards the treatment goals.

6. Client records are both the property of Crossroads and the client. First we must receive a written request from you. Then we will schedule a time to review the written records, in case there are any questions about the records. However, the State of Iowa does allow us the option to protect a child's records and not release the child's records to either parent, if we determine that it would not be in the child's best interests to release the records.
We do not wish to release written records, so that we may protect a child's confidentiality. We would hope that you enter therapy to truly help your child and give them a place of sanctity to explore themselves and their feelings. Our goal is to bring families together; it is not to exclude anyone. For a child, each family member is important to them.

7. The client, parents, and legal guardians, agree and acknowledge that the counselor will not be asked to testify on behalf of client, parents, or legal guardians, at any judicial proceedings or depositions, in which the client, parents, or legal guardians may be involved.However, if the counselor later agrees to testify at future judicial proceedings or depositions, or is properly served a subpoena, the client, parents and legal guardians hereby agree to pay expert witness fees to procure counselor's testimony. Crossroads will require, and the parent or parents agree to pay, a $500.00 deposit toward expert witness fees prior to the counselor undertaking testimony at a judicial proceeding, deposition, preparation, consultation, testimony, or travel time. Expert witness fees shall include a <u>minimum</u> fee of one hour. The counselor may charge a reasonable expert witness fee, based on the counselor's usual and customary hourly rate. It is possible that the counselor's fee may exceed $500.00. If the counselor's reasonable expert witness fee does not exceed $500.00 at the conclusion of the counselor's litigation-related services, any excess funds will be returned to the parent who paid the deposit.

8. The parents agree that they will not request the child's written records to be submitted to their attorney, opposing attorneys, or submitted to the Court. In consideration of the parent's promise, Crossroads agrees to provide counseling services for your child. Our experience is that verbal testimony is more helpful than having our records submitted to the Court, as there is the possibility that the records may be taken out of context. Again, our goal is to help your child find peace in a difficult situation, rather than create a more adversarial situation.

**X**_____ **X**_____

Client Name/Signature Date Legal Guardian Signature Date

# CROSSROADS COUNSELING CENTER

**PRIVACY NOTICE ACKNOWLEDGEMENT**

Crossroads Counseling Center
300 Main Street, Suite 230
Dubuque, IA 52001

I hereby acknowledge that the Crossroads Counseling Center has provided the Privacy Notice as required by the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Client Name – Signature Date

_____ _____

Parent/Guardian Name – Signature Date

** If client refuses to acknowledge receipt of the Privacy Notice