Christian Community Placement Center

MHC Intake Packet – Youth

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ County: _____

Gender: ☐Male ☐Female ☐ Other: _____ Ethnicity: _____

PARENT INFORMATION

Parent/Guardian Name: _____ Relationship to Client: _____

Address (if different): _____

City/State/Zip: _____

Home Phone: _____ Okay to leave message? ☐ Yes ☐ No

Cell Phone: _____ Okay to leave message? ☐ Yes ☐ No

Work Phone: _____ Okay to leave message? ☐ Yes ☐ No

May we call for appointment reminders? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

How were you referred to CCPC? _____

INSURANCE INFORMATION

IS YOUR CHILD COVERED BY INSURANCE? ☐ Yes ☐ No (If 'No', skip to next section)

Insurance Type: ☐Medicaid ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: _____ Phone: _____

Address: _____ City/State/Zip: _____

Plan Name: _____ Policy #: _____ Group #: _____

IS YOUR CHILD COVERED BY MORE THAN ONE INSURANCE PROVIDER? ☐ Yes ☐ No (If 'No', skip to next section)

Insurance Type: ☐Medicaid ☐ Oregon Health Plan ☐ Private Group Health Plan ☐ Other

Insurance Company: _____ Phone: _____

Address: _____ City/State/Zip: _____

Plan Name: _____ Policy #: _____ Group #: _____

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MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

PCP Clinic Name: _____

Address: _____ City/State/Zip: _____

Has your child seen their PCP within the last year? ☐ Yes ☐ No

If yes: ☐Routine Visit ☐Other (please explain): _____

Has your child begun showing signs of puberty? ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No

If yes, what allergies and what medications are taken? _____

	YES	NO		YES	NO
Accidents / Major Injuries (car, bike, sports, etc.)			Hospitalizations / ER visits (non-psychiatric)		
Allergies / Hay Fever			Ever been pregnant / suspected pregnant		
Asthma / Lung Problems			Recurring infections		
Chronic Illness / Disease (Diabetes, hepatitis, etc.)			Seizures / Epilepsy		
Headaches			Surgeries		
Head injuries / trauma			Vision Problems		
Hearing Problems			Other (please specify)		

Please explain items checked 'Yes': _____

MEDICAL INFORMATION, CONTINUED

Pharmacy: _____ Phone: _____

Address: _____ City/State/Zip: _____

CURRENT MEDICATIONS

Name of Medication	Dosage	How long has child taken?	For What?	Prescriber

Do you suspect or know that your child used or experimented with using tobacco products? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you suspect or know that your child used or experimented with using alcohol? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you suspect or know that your child regularly consumes caffeinated drinks? ☐Current ☐Past ☐ No

If current, how often? _____ How much? _____

Do you suspect or know that your child has used, or has experimented with using drugs? ☐Current ☐Past ☐ No

If yes, which drugs? ☐ Marijuana ☐Hallucinogens ☐ Heroin ☐ Inhalants ☐ Methamphetamines

☐ Prescription Opiates ☐ Other: _____

If current, How often? _____ How much? _____

If yes, has their use of substances created a problem for them at: ☐Home ☐School ☐Personal Relationships ☐ No

If so, please explain further: _____

MENTAL HEALTH INFORMATION

What is the primary reason for seeking counseling? Circle as many as apply:

Anger Anxiety Depression Grief/Loss Self-Harm Trauma

Other (please specify): _____

Briefly describe your reason for seeking counseling: _____

Has there been a history of child abuse? ☐ Yes ☐ No ☐ Suspected

If yes, which type(s): ☐ Sexual ☐ Physical ☐ Verbal ☐ Domestic Violence

If yes, was the abuse as a: ☐ Victim ☐ Perpetrator ☐ Witness

Other childhood issues: ☐ Neglect ☐ Inadequate Nutrition ☐ Other (please specify): _____

Has your child ever been in counseling before? ☐ Yes ☐ No

If yes, how long was your child in counseling? _____

What was the outcome of your child's counseling experience? _____

Has your child ever had a psychological evaluation? ☐ Yes ☐ No

If yes, with whom? _____

Has your child ever been prescribed any psychiatric medications? ☐ Yes ☐ No

If yes, what medications? _____

Has your child ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please describe the reason and duration: _____

MENTAL HEALTH INFORMATION, CONTINUED

Were there any complications with the pregnancy or delivery of your child? ☐ Yes ☐ No

If yes, please describe: _____

Were there any delays/issues meeting developmental milestones (walking, talking, toilet training, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have a history or current issue with speech development? ☐ Yes ☐ No

If yes, please describe: _____

Are there special, unusual, or traumatic circumstances that affected your child's development? ☐ Yes ☐ No

If yes, please describe: _____

Briefly describe your child's temperament and strengths: _____

Briefly describe your child's relationship with their parents: _____

Briefly describe your child's relationship with their siblings: _____

Additional information related to their childhood development: _____

SCHOOL INFORMATION

School: _____ Highest Grade Completed: _____

School Contact Person: _____

How would you describe your child's experience at school? _____

What are your child's favorite subjects and school activities? _____

What subject does your child least enjoy and why? _____

Is your child on an IEP plan at school? ☐ Yes ☐ No

Is your child on a 504 plan at school? ☐ Yes ☐ No

Has your child ever been suspended/expelled from school? ☐ Yes ☐ No

Does your child have a problem with skipping school? ☐ Yes ☐ No

Does your child have many friends at school? ☐ Yes ☐ No

SYMPTOM CHECKLIST

Please check any symptoms that your child has experienced in the past year:

- ☐ Sleep Problems
  - ☐ Too much
  - ☐ Difficulty getting to sleep
  - ☐ Frequent waking
  - ☐ Waking, unable to get back to sleep
  - ☐ Feeling no need for sleep
- ☐ Nightmares
- ☐ Difficulty concentrating / thinking / decision making
- ☐ Easily angered / angry / outbursts
- ☐ Isolated / withdrawn
- ☐ Regression in developmental milestones
- ☐ Homicidal thoughts
- ☐ Running away
- ☐ Vandalism
- ☐ Property damage / destructive
- ☐ Gang interest / involvement
- ☐ Fire starting
- ☐ Stealing
- ☐ Lying
- ☐ Sexually reactive
- ☐ Sexual offending
- ☐ Sexuality concerns
- ☐ Sexual identity issues
- ☐ Depressed mood
- ☐ No interest / pleasure in activities
- ☐ Feeling fatigue / loss of energy
- ☐ Change in appetite:
  - ☐ Increased
  - ☐ Decreased
  - ☐ Weight change
- ☐ Change in eating habits:
- ☐ Bingeing
- ☐ Purging
- ☐ Excessive exercise
  - ☐ Excessive dieting / fasting
  - ☐ Pica (eating non-food items such as soap, dirt, chalk, etc.)
  - ☐ Nutritional Deficiencies
  - ☐ Underweight
  - ☐ Overweight
- ☐ Feelings of worthlessness
- ☐ Feelings of extreme guilt
- ☐ Suicidal thoughts
  - ☐ Plans
  - ☐ Attempts
- ☐ Self-harm
- ☐ Feelings of emotional numbness / detachment
- ☐ Problems beginning or keeping relationships
- ☐ Tantrums
- ☐ Memory problems
  - ☐ Remembering last day or two
  - ☐ Remembering distant past
  - ☐ Loss of time
- ☐ Encopresis (soils)
- ☐ Enuresis (wets)
- ☐ Agitation / restlessness
- ☐ Extreme irritability
- ☐ Racing thoughts
- ☐ Easily distracted difficulty finishing tasks
- ☐ Excessive energy level
- ☐ Excessive worry / fear
- ☐ Panic attacks

  Frequency:
- ☐ "On edge" or easily startled
- ☐ High anxiety
- ☐ Recurrent / persistent disturbing thoughts
- ☐ Repetitive or compulsive behavior
- ☐ Flashbacks / trauma easily triggered by other events
- ☐ Hallucinations
- ☐ Thoughts or experiences seem strange or odd
- ☐ Intrusive / unwanted thoughts
- ☐ Extremely elevated mood

Please describe any other symptoms your child has been experiencing: _____

Welcome

We at Christian Community Placement Center welcome this opportunity to assist you in your desire to resolve your problems through counseling. You will be encouraged to clarify your options and make choices that will increase your personal satisfaction and enhance your physical, mental, and emotional health.

Appointments

Appointments will be scheduled with the business office and usually last 50 minutes for counseling. Please be approximately 15 minutes early for the initial appointment to fill out paperwork, and please bring any insurance information at that time, including ID and group numbers. Due to our therapist's busy schedules, If you are more than 15 minutes late for your appointment we will be unable to see you and you will then need to reschedule for another appointment time.

You are responsible for the payment of all charges incurred. Our policy is that we request payment at the time of the session. We are happy to assist you by billing your insurance company on your behalf. You will receive a monthly statement of your account, and prompt payment of any outstanding balance is requested.*****

Cancellations

Cancellations require a full 24-hour notification so that we have an opportunity to reschedule that time slot. If three (3) scheduled appointments are missed without 24 hour notice, Christian Community Placement Center reserves the right to terminate services. Please ask if you have questions regarding this policy, as we do enforce it.

Leaving Messages by Phone

Office hours are 9am to 5pm, Monday through Thursday and 9am to 2pm on Fridays. Our answering machine operates 24 hours a day, so you can leave a message at night, on weekends or holidays, or even during the workday should we be unavailable to answer the phone.

Emergency Contacts

IN THE EVENT OF A Life Threatening Emergency and you need immediate assistance, please call 911

Or

Christian Community Placement Center's on-call number during after hours. (503)507-7183

Please call the office number during normal business hours.

Christian Community Placement Center (503)588-5647

Other emergency numbers

Psychiatric Crisis Center	503-585-4949
Northwest Human Services 24-hour crisis hotline	503-581-5535
Marion County Drug Treatment	503-588-5358
Harmony House Detox Center	503-399-5597
Marion County Children's Crisis Center	503-585-4909
Women's Crisis Center	503-399-7722

Risks vs. Benefits

As in anything new, there are inherent risks in a treatment relationship. Due to the intense nature of self-evaluation and awareness, clients typically experience a range of emotions coupled with periods of imbalance. These periods lend themselves to states of confusion and disorganization. However, as in any growth process, the ups and downs usually balance out. If you choose not to seek treatment or outside assistance, you may find that doing nothing results in no change of your condition or behavior.

Consent to Treatment

I have requested treatment from Christian Community Placement Center (CCPC). I understand that testing, diagnostic procedures, and therapy are determined and administered through profession judgments made by CCPC Staff. This treatment may include individual and/or group therapy, and may include consultations with CCPC Counselors, Prescribers and other CCPC Staff/outside clinical supervision consultants. I understand that treatment procedures will be developed according to a mutually agreed upon treatment plan between me, my child (if receiving treatment) and the CCPC staff. I also understand that I will be given an explanation of the purpose of any prescribed medication and potential side effects.

I understand that I am free to withdraw from this relationship at any time, and I agree to attend a closing session upon termination of treatment. I also understand that I am free to file a grievance at any time.

Fees*

Counseling fees are:	Initial Session $175.00
60 Minutes $125.00	20 minutes $50.00

Payment of Fees

You are responsible for the payment of all charges incurred. Our policy is that we request payment at the time of the session. We are happy to assist you by billing your insurance company on your behalf. You will receive a monthly statement of your account, and prompt payment of any outstanding balance is requested.*** *Not applicable for OHP**

PCP Communication

You or your child has enrolled in services with CCPC. As part of your treatment, Oregon law mandates that we communicate with your Primary Care Physician to coordinate your behavioral, physical and mental health needs. You do not need to sign any additional releases of information. This communication will continue throughout the course of your treatment here. Shared information will include, but is not limited to:

- Prescribed medications
- Significant changes in medications or treatment approach
- Diagnosis and HIV status
- Termination of service

Individual's Rights

CCPC supports and protects the fundamental human, civil, constitutional and statutory rights of each individual. Every individual will be treated with dignity, hope and respect. Our agency provides each individual with a copy of his or her rights.

The following is a list of Individual's Rights:

1. Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;
2. Be treated with dignity and respect;
3. Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;
4. Have all services explained, including expected outcomes and possible risks;
5. Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.
6. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:
    a. Under age 18 and lawfully married;
    b. Age 16 or older and legally emancipated by the court; or
    c. Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;
7. Inspect their Service Record in accordance with ORS 179.505;
8. Refuse participation in experimentation;
9. Receive medication specific to the individual's diagnosed clinical needs;
10. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;
11. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
12. Have religious freedom;
13. Be free from seclusion and restraint;
14. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
15. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;
16. Have family and guardian involvement in service planning and delivery;

Individual's Rights, continued:

17. Make a declaration for mental health treatment, when legally an adult;
    File grievances, including appealing decisions resulting from the grievance;
18. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;
19. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and
20. Exercise all rights described in this rule without any form of reprisal or punishment.

Oregon Health Plan and Mid-Valley Behavioral Health Plan clients have additional rights and responsibilities that are posted and available in a handout. Upon request, CCPC can offer this form in alternative formats or languages.

CCPC's Individual Client Guidelines

As in anything new, there are inherent risks in a treatment relationship. Due to the intense nature of self-evaluation and awareness, clients typically experience a range of emotions coupled with periods of imbalance. These periods lend themselves to states of confusion and disorganization. However, as in any growth process, the ups and downs usually balance out.

If you choose not to seek treatment or outside assistance, you may find that doing nothing results in no change of your condition or behavior.

You deserve to have a healthier, happier, more functional life. You will gain the maximum benefit from our program if you are open, honest, and willingly participate in individual and group therapy.

Here are some hints for successful individual and group sessions:

- ✧ Stay open to the process
- ✧ Be aware of what you are feeling
- ✧ Share your feelings with your therapist or group members
- ✧ Complete journal and writing assignments; denial has a difficult time surviving in writing
- ✧ Ask questions (there are no dumb questions)
- ✧ Have courage to change

Individual's Grievance Procedure

1. Any complain/grievance which is not mutually resolved between individuals or between individuals and staff shall be communicated to any staff member of Christian Community Placement Center either in writing or orally so that it can be reduced to a clear, concise written report. This will be give to the Executive Director to be logged in the Complaints Log.
2. In response to receipt of such written complaints/grievances, the Executive Director shall immediately investigate and will try to complete the process in 5 working days. If more time is needed, the individual will be notified in writing. We will inform the individual of reason why and how much more time is needed to resolve the issues. The longest about of time for the complaint to process is 30 calendar days following receipt. This will be recorded in the Complaint Log and a file will be kept of all complaints received for 2 years.

For MVBCN Individuals: Please refer to the handout "Our Process for Complaints and Feedback" that is available in the lobby, from the receptionist, or at www.mvbcn.org.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please consult your Therapist.

Christian Community Placement Center

Email: receptionist@ccpcusa.com

4890 32nd Ave. SE, Salem OR 97317

(503) 588-5647

WHO IS SUBJECT TO THIS NOTICE:

This notice describes the privacy practices of **Christian Community Placement Center (CCPC)** and the social workers, therapists, counselors, nurses and other individuals and staff that work at **Christian Community Placement Center**.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the care and service you receive from CCPC. Your health information may include information created and received by CCPC, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

Uses and Disclosures with Your Consent

Except in an emergency or other special circumstances, we will ask you to read and sign a written consent regarding the uses for and the disclosure of Protected Health Information for purposes of: treatment provided to you, obtaining payment for services provided to you and for our health care operations (e.g., internal administration, quality improvement and customer service) as detailed below:

- Treatment – We may use and disclose Protected Health Information to provide treatment and other services to you. For example, to diagnose and treat your illness or to phone in prescriptions for you.
- Payment – We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, health plan, or a third party. For example, we may need to give your health plan information about a service you've

received so your health plan will pay for the service. We may need to disclose information to a collection agency to assist in the collection of a past due account.

- Health Care Operations – We may use and disclose Protected Health Information for our health care operations. They include internal administration and planning and various activities that improve the quality and cost effectiveness of the care we deliver to you. For example, we may use Protected Health Information to evaluate the quality and competence of our clinical staff and other health care workers.
- Business Associates – We may contract with business associates to perform certain functions or activities on our behalf, such as treatment, payment and health care operations. These business associates must agree to safeguard your Protected Health Information.
- Organized Health Care Arrangement – For Mid-Valley Behavior Care clients, we are a member of the Marion County Integrated Delivery System (IDS) and we may share information as needed among member agencies for the purposes of treatment, payment and health care options.
- Appointment Reminders – We may contact you as a reminder that you have an appointment for treatment or clinical care at Christian Community Placement Center.
- Treatment Alternatives and Related Products and Services – We may tell you about or recommend possible treatment options or alternatives, or related products or services that may be of interest to you.

Please notify us if you do not wish to be contact for appointment reminders, or if you do not wish to receive communications about treatment alternatives or related products and services. If you advise us **in writing** (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Uses and Disclosures of Your Highly Confidential Information – When we are using or disclosing certain Protected Health Information about you that is deemed highly confidential information, we follow special procedures required by federal and Oregon laws Highly Confidential Information includes psychotherapy notes and Protected Health Information about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing; (4) venereal disease(s); (5) genetic testing; (6) child abuse and neglect; and (7) sexual assault. We use and disclose Highly Confidential Information with your knowledge and limited by a particular purpose.

Your Consent only permits us to use Protect Health Information for purposes of treatment, payment and our health care operations. We may not use or disclose Protect Health Information for any reason other than treatment, payment and health care operations accept when (1) you give us your authorization form or (2) there is an exception described below. Further, you may revoke your Authorization in writing at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To avert a serious threat to health or safety** - We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety or the public or another person.
- **Public health activities -** We may disclose Protected Health Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
- **Victims of Abuse, neglect or Domestic Violence –** We may disclose Protected Health Information without Your Consent or Your Authorization to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. This may include a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
- **Health Oversight Activities** - We may disclose Protect Health Information to a health oversight agency that is responsible for a health care system or that ensures compliance with the rules of government health programs such as Medicare or Medicaid.
- **Judicial and Administrative Proceedings** - We may disclose Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. [164.512(e)] However, unless authorized by court order, we may not use or disclose Protected Health information identifying you as a recipient of substance abuse treatment or concerning such treatment if the purpose is to initiate or substantiate any criminal charges against you or to conduct any investigation of you.
- **Law and Enforcement Officials** – We may disclose Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order.
- **Decedents** – We may disclose Protected Health Information to a coroner or medical examiner as authorized by law.
- **Research** – We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.
- **Specialized Government Functions** – We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends** - We may disclose health information about you to your family members or friends if we obtain your authorization to do so. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into your session.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy** – You have the right to inspect and receive a copy of your health information, such a clinical and billing records, that we keep and use to make decisions about your care you must submit a written request to our receptionist in order to inspect and/or copy records or your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.
- **Right to Amend** – You have the right to request that we amend Protect Health Information maintained in your record file or billing records. If you desire to amend your records, please obtain an amendment request form from the receptionist and submit the completed form to your therapist.

  We may deny your request for an amendment if your request is not in writing or does not include your reason to support that request. In addition, we may deny your request if you ask us to amend information that (1) we did not create, (2) is not part of the health information that we keep, (3) you would not be permitted to inspect and copy, or (4) is accurate and complete.

- **Right to an Accounting of Disclosures** – You have the right to request and "accounting of disclosures." This is a list of disclosures we made regarding clinical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. In addition, the list will not include any disclosures we have made based on your written authorization.

  To obtain this list, you must submit your request in writing to the billing department. It must state a time period, which may not be longer than six years and may not include dates before February 1st, 2015. If you request an accounting more than once during a twelve (12) month period, we may charge a fee.

- **Right to Request Restrictions** – You may request that we limit our uses and disclosures of your Protected Health Information for treatment, payment, and health care operations purposes. However, by law, we do not have to agree to your request. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION USE OF CLINICAL INFORMATION FORM to the receptionist. We will send you a written response.
- **Right to Request Confidential Communications** – You have the right to request that we communicate with you about clinical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communication, you need to complete and submit the REQUEST FOR RESTRICTION USE OF CLINICAL INFORMATION to the receptionist. We will not ask you the reason for your request. We will attempt to accommodate all the reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Receive a Copy of this Notice** – You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effect date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

By signing below, I am:

- Agreeing that I have read and reviewed **CCPC's standards** for
  - **Appointments**
  - **Cancellations**
  - **Consent to treatment**
  - **Fees**
  - **Payments of fees**
  - **PCP communication**
  - **Reminder phone calls**
- Agreeing that I read and received the list of **individual rights**.
- Agreeing that I read and received **CCPC's individual client's guidelines**.
- Agreeing that I read and received **CCPC's grievance procedure**.
- Agreeing that I read and received **The Notice of Privacy Practices.**
- Agreeing that I read and received my therapist's **Professional Disclosure Form.**
- I understand that counseling is a structured process which depends upon building relationship and consistent participation over time, and as the parent/guardian, that part of my role in my child's treatment is to ensure that my child attends all scheduled appointments.

Client Name Date

Client or Parent/Guardian Signature Date