

Adult

Saratoga Center for the Family
Client Information Sheet

Preferred Name: _____

Legal Name: _____ Gender Identity: _____

Date of Birth: _____ County of Residence: _____

Address: _____

Telephone (home) _____ (work) _____ (cell) _____

May we leave messages at these numbers? (Y/N) (home) _____ (work) _____ (cell) _____

Emergency contact name and number:

Current Marital Status: _____

Employment: Full Time _____ Part Time _____ Unemployed _____

Occupation: _____

Employer: _____

Primary Care Doctor: _____ Phone: _____

Grade or highest education level completed: _____

Ethnicity: Caucasian/White African-American Asian
 Hispanic/Latino Native American Other: _____

Yearly Household Income:

\$0-9,999 \$10,000-14,999 \$15,000-24,999
 \$25,000-34,999 \$35,000-49,999 \$50,000 and up

Who referred you/how did you find out about us?

Social Services Court Primary Care Doctor Saratoga County Mental Health

Other: _____

Office Use Only

PA SA DV BEH

Other

Client's Name _____ Date of Birth _____

HAS THE CLIENT HAD? (Mark Y/N)	Yes	NO	HAS THE CLIENT HAD? (Mark Y/N)	Yes	NO
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		
Surgeries:					
Hospitalizations:					

If you wish to provide further details about any of the above, please use this space: _____

List any medications to which the client is allergic: _____

In general, would you say the client's health is: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

Does the client get 20 to 30 minutes of exercise at least three times a week? ___ Yes ___ No

Is the client at a healthy weight as recommended by his/her physician? ___ Yes ___ No

You may be answering the following for yourself or, if your child is the client, completing this on his/her behalf. Please base the answers upon what has been experienced in the past month:

	<u>STRONGLY AGREE</u>	<u>AGREE</u>	<u>DISAGREE</u>	<u>STRONGLY DISAGREE</u>
1. The client feels good about him/herself.	___	___	___	___
2. The client can deal with his/her problems.	___	___	___	___
3. The client accomplishes the things he/she wants.	___	___	___	___
4. The client has friends or family that he/she can count on.	___	___	___	___

WARNING: This is privileged and confidential client information. Any unauthorized disclosure is a federal offense. Not to be duplicated. Please handle, store, and dispose of properly. Permission to send these records to you has been given to the Center in writing by the concerned client or his or her guardian. You do not have the legal right to share these records with any other person, agency, organization, or program unless you first obtain written permission to do so from the subject of these records or his or her guardian.
 (Rev. 1/18/13 CJD)

If an Adult client, please complete the following section. Again, please base the answers upon what has been experienced in the past month:

<i>How much did the following problems bother you?</i>	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
1. Nervousness or shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling sad or blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeling hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling everything is an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your heart pounding or racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Feeling fearful or afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Difficulty at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Difficulty socially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Difficulty at work or school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the client is a Child (under age 18), the parent or guardian completes this section about the child. Again, please base the answers upon what has been experienced in the past month:

<i>What best describes the child?</i>	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
1. Destroyed property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Was unhappy or sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Behavior caused school problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Had temper outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Worrying prevented him/her from doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Felt worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Had trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Changed moods quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Used alcohol or drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Was restless, trouble staying seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Engaged in repetitious behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Needed constant attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>How much have your child's problems caused...?</i>	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
1. Interruption of personal time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Disruption of family routines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Less attention paid to any family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Disruption or upset of relationships within the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Disruption or upset of family's social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Were there any concerns during the mother's pregnancy or the delivery? If "YES", please explain:

Were developmental milestones met on time? If "NO", please explain:

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 (Rev. 1/18/13 CJD)

Saratoga Center for the Family
Insurance/Payment Information

Client name: _____ Date: _____

Client date of birth: _____

Primary care physician: _____ Phone: _____

Does the client have health insurance? ___ yes ___ no. *If yes, complete below. If no, speak to the receptionist about our Financial Assistance Program.*

Insurance company: _____

Insurance member number: _____

Group number: _____

Name of policy holder: _____ Relationship: _____

Policy holder date of birth: _____

Policy holder place of employment: _____

I authorize release of any medical or other information to my insurance company as necessary to obtain payment in compliance with the Health Insurance Privacy and Portability Act (1996). I also authorize payment of benefits directly to Saratoga Center for the Family.

Signature: _____ Date: _____

Relationship to insured: _____

Please notify us and complete a new form if your insurance changes in any way.

Office use only:

Above insurance changed on date: _____

New form completed on date: _____

Saratoga Center for the Family
359 Ballston Avenue
Saratoga Springs, NY 12866
Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" handout and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment no less than 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I am aware that non-identifying information about me may be used for quality assurance, treatment evaluation, and other service monitoring and/or research purposes.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

Copy accepted by client Copy kept by therapist

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(Rev. 11/20/14 KD)

Saratoga Center for the Family
359 Ballston Avenue
Saratoga Springs, NY 12866
Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Saratoga Center for the Family.
When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, <http://www.saratogacff.org>, or by calling us at 518-587-8008, or from our Clinical Director.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative Date

Printed name of client or personal representative Representative's relationship to the client

Therapists Signature Date

Date of NPP: _____ Copy given to the client/parent/personal representative

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TRSTRAUMA RECOVERY SCALE

J. Eric Gentry

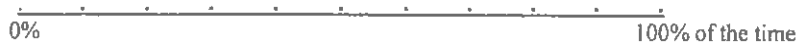
PART III

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.



2. I sleep free from nightmares.



3. I am able to stay in control when I think of difficult memories.



4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).



5. I am safe.



I feel safe.



6. I have supportive relationships in my life.



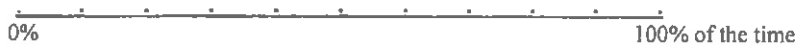
7. I find that I can now safely feel a full range of emotions.



8. I can allow things to happen in my surroundings without needing to control them.



9. I am able to concentrate on thoughts of my choice.



10. I have a sense of hope about the future.



AS - FS

Scoring Instructions: record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

Interpretation: 100 - 95 (full recovery/subclinical); 86 - 94 (significant recovery/mild symptoms); 75 - 85 (some recovery/moderate symptoms); 74 (minimal recovery/severe); below 35 (probable traumatic regression)

Mean Score



SARATOGA CENTER FOR THE FAMILY
Building stronger families throughout Saratoga County

INFORMATION FOR CLIENTS

What you should know before entering treatment

Saratoga Center for the Family (SCF) is a private, not-for-profit agency serving Saratoga County and surrounding communities. SCF is committed to strengthening, empowering and improving the emotional wellbeing of children, families and the community, and to reduce the incidence and effects of child abuse and neglect.

Individual/Family Counseling:

Counseling at our center includes meeting with a therapist at predetermined intervals of time (e.g., weekly, bi-weekly). Therapy can cover a range of topics depending on the purpose for seeking treatment. There are no physical risks associated with therapy, although in the beginning an increase in emotional distress can occur as issues and topics are being brought up. Please speak to your therapist if you have any concerns. Therapists at Saratoga Center for the Family are professionals holding masters or doctoral degrees in social work, marriage and family therapy, mental health counseling or psychology. The Center also sometimes acts as a training site for interns who are pursuing licensure in their field. All interns are supervised by licensed staff.

Custody:

- The therapists at SCF are not trained in custody evaluation. You must seek outside providers for this service. If called to appear in court, we will not speak to custody issues.

Court Appearances:

- If we appear in court at your request and on your behalf, you are responsible for our fee of \$150.00 an hour.

Ending Services:

- **No-show and Late Cancellation Policy:** The staff at SCF strives to provide the best services possible. Therefore, your appointment time is reserved especially for you. If you have to cancel your appointment, please call us at 587-8008 no less than 24 hours before your appointment. *If you miss two appointments without notifying us, we will discharge you as a client and if you have 3 same day cancels the therapist may choose to discharge you from treatment and you will have to undergo the intake process again if you wish to return to care.*
- A client may be discharged if he/she exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic.
- A client may be discharged if he/she refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.
- Clients will be notified of non-voluntary discharges by letter. The client may appeal this decision with the Clinical Director or request to reapply for services at a later date.
- A client may end services at any time. Clients are strongly encouraged to discuss this decision with their therapist.

Fees:

- If you have health insurance that provides mental health coverage your insurance carrier will be billed for services.
- Your co-pay will be due at the time of service. If you do not have health insurance or have health insurance but no mental health coverage you can speak to the center's advocate about a financial assistance program. An affordable fee will be set for treatment, which will be due at the time of service.
- Payment for services is the responsibility of the client, or a person who has agreed to provide payment. When payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame, and the name of the clinic or collection source.

our Rights as a Client:

- **Complaints:** We will investigate your complaints.
- You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.
- **Suggestions:** You are invited to suggest changes in any aspect of the services we provide.
- **Civil rights:** Your civil rights are protected by federal and state laws.



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- **Cultural/spiritual/gender issues:** You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
- **Treatment:** You have the right to take part in formulating your treatment plan.
- **Denial of services:** You may refuse services offered to you and be informed of any potential consequences.
- **Medical/legal advice:** You may discuss your treatment with your doctor or attorney.
- **Disclosures:** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized. Request this in writing.
- **Crisis Services:** The SCF does not provide crisis services. If someone is at risk for serious harm: CALL 911 OR GO OTHE NEAREST EMERGENCY ROOM.
- **After Hours Contact:** SCF's typical hours of operation are M-F from 8AM to 5PM. You may leave after hours voice mail messages for your therapist by calling the main number at 518-587-8008 and following the menu. Therapists are expected to check their voice mail messages once every 24 hours M-F.

Your rights to receive information:

- **Costs of services:** We will inform you of how much you will pay.
- **Termination of services:** You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
- **Confidentiality:** You will be informed of the limits of confidentiality and how your protected health information will be used.
- **Policy changes:** We will do our best to immediately inform you of policy changes that may affect you.

Our Ethical Obligations:

- We dedicate ourselves to serving the best interest of each client.
- We are committed to providing care in a manner that supports and protects the personal dignity of each client.
- We are committed to providing care that reflects 'best practices' and evidence-based treatments.
- We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
- We maintain an objective and professional relationship with each client.
- We respect the rights and views of other mental health professionals.
- We will appropriately end services or refer clients to other programs when appropriate.
- We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
- We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.
- We will provide ongoing discussions with you about how and with whom your information is shared.

Patient's responsibilities:

- You are responsible for your financial obligations to the clinic as outlined above.
- You are responsible for following the policies of the clinic.
- You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
- You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated:

○ Express your concerns with your therapist. If this does not resolve the problem, then: Contact our Executive Director, Ms. Rebecca Baldwin, at 518-587-8008, ext. 303. If she cannot help, then, share your concerns with the following agency:

NYS Office of Mental Health Commissioner
Customer Relations Service: 1-800-597-8481 or En Espanol: 1-800-210-6456 TDD (for those who are deaf/hearing impaired): 1-800-597-9810
99 Washington Avenue, Suite 1002, Albany, NY 12210
General Phone: 518-473-4090 or 1-800-624-4143



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This handout is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this handout) about any questions or problems.

How we use and disclose your protected health information with your consent We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Fundraising: We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Disclosing your health information without your consent:

There are some times when the laws require us to use or share your information. For example:

- When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
- When we are required to do so by lawsuits and other legal or court proceedings.
- If a law enforcement official requires us to do so.
- For workers' compensation and similar benefit programs.
- There are some other rare situations. They are described in the longer version of our notice of privacy practices.



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Your rights regarding your health information:

- You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
- You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Wende Tedesco , LCSW-R and can be reached by phone at 518-587-8008 or by e-mail at wtedesco@saratogacff.org.

The effective date of this notice is January 1, 2014