



Penrod

Counseling
Center

“Treatment with Compassion”

317-272-5247

Fax: 272-1340

www.penrodcc.com

Offices: **Avon** - 6845 E US Hwy 36 Ste 440, Avon, IN 46123 **West** – 3410 N. High School Road, Indianapolis, IN 46224

Initial Assessment – Part 1

Name _____ Date _____

First MI Last

Address _____

Street City Zip Code County

Home Phone: _____ Work Phone: : _____ Cell Phone/ Etc. : _____

SS#: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____ Sex: M F

(SS# is Necessary if You Want to be Charged Sliding-Fee Scale)

Race: African American Asian Hispanic Native American White Multi-Racial Other

(The Indiana Department of Mental Health Requires us to Compile Race Information)

Marital Status: Single Married Live-in Relationship Divorced Separated Widowed

Of Children _____ Currently Pregnant? Yes No Height: _____ Weight: _____

Children's Names and Ages: _____

Others who may be in counseling with you: _____

Medical Conditions: _____ Medications: _____

General Physical Condition: _____

Family Physician: _____ Phone: _____ - _____ - _____

Physical or Mental disabilities: Y N Explain: _____

Insurance Company: _____ Co-Pay Amount: \$ _____

Medicaid ID # _____ Medicare ID # _____

TANF Enrolled: Yes No Hearing Impaired: Yes No Food Stamps: Yes No

Approximate Annual Family Income: \$ _____ Family Size: _____

(Necessary if you want to be charged Sliding Fee Scale--Income Subject to Verification)

Emergency Contact: _____ Phone: _____ Referred By: _____

Students: Where do you attend school? _____ What grade are you in? _____

What are your favorite subjects? _____ Least favorite? _____

Do you have transportation to/from appointments Y N Preferred Language: _____

Have you ever been in counseling before? Y N Please describe: _____

Reason for terminating previous counseling: _____

Client Name: _____

Please read the following two sections (I, "Consent to receive Services at PCC" and II, "Confidentiality of Alcohol and Drug Abuse Client Records"). Your Signature **is required** On each prior to being seen by our staff:

I. I Consent to Receive Services at PCC: I agree to be evaluated and treated by Penrod Counseling Center Staff. If I am a Substance Abuse Client, I agree to submit to Urine Drug Screens at the request of my therapist. I understand that I will be responsible for the cost of the Urine Drug Screens whether or not they are done randomly. I understand that the cost of my treatment will be based on my family income, and that I am financially responsible for all costs associated with my treatment, and I agree to pay those costs in full. The agreement to pay fees begins with your first session. If you are to have a Urine Drug Screen today, there is an \$18 Charge).

Signed X _____ Parent or Guardian _____

II. Confidentiality of Alcohol and Drug Abuse Client Records:
Federal Law and Regulations protect the confidentiality of alcohol and drug abuse records maintained by this program. Generally, the program may not say to a person outside the program that a client attends a program or disclose any information identifying a client as an alcohol or drug abuser unless:

1. The client consents in writing,
2. The discloser is allowed by court order; or
3. The discloser is made to medical personal in a medical emergency or to qualified personal for research, audit or program evaluation.

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported to State or Local authorities.

(See U.S.C. 290dd-3 and U.S.C. 290ee-3 for Federal laws and CFR for Federal Regulations)

I have read and understand the above confidentiality information.

X _____	X _____
(Client Signature)	(Witness Signature)
_____	_____
(Date Signed)	(Date Signed)

Briefly describe why you are here.

Any other areas of concern that you would like to discuss (circle):

- | | | | | |
|------------------|-------------------|--------------------------|----------------------------|-------------|
| Family Issues | Domestic Violence | Women's Issues | Marital Counseling | Pre-Marital |
| Grief | Anger Management | Mental Health Evaluation | Child/Spouse Abuse/Neglect | |
| Counseling for: | Foster Care | Adoption | Grandparents | |
| Parenting Skills | Life Skills | Substance Abuse | Other: _____ | |

Do you attend church? Y N Where? _____ Member? Y N

Frequency of attendance: _____ Do you participate in Bible Study or Small Group classes? Y N

Activities: _____

Hobbies: _____

Client Name: _____

If you have an Alcohol-related charge, what was your Blood Alcohol Content (BAC)?: _____

If you are on probation, when did it begin?: _____ When does it end?: _____

Alcohol:

Age of your first drink: _____ Age of your first intoxication: _____

Age drinking first caused you a problem: _____ The problem was: _____

Age of the first time you drank more than you had planned to drink: _____

Date of your last drink: _____ - _____ - _____

Explain: _____

Other Drugs:

Age first drug was used: _____ What Drugs? _____

Age drug use first caused you a problem? _____ The problem was: _____

Age of the first time you used more of a drug than you had planned to use: _____

Date of last drug use: _____ Explain: _____

Do you now have or have you ever had any of the following (circle)?

Shakes Feel Shaky Inside Profuse Sweating Hallucinations Seizures

Explain: _____

Have you ever had any other withdrawal symptoms from Alcohol or any other Drug? Yes No

Explain: _____

Have you ever been in a detoxification program? Y N Explain: _____

How often do/did you: Drink? _____ Use drugs? _____

How much do/did you spend per week on: Alcohol \$ _____ Drugs \$ _____

How much does/did it take you to feel the effect: Alcohol? _____ Drugs? _____

What is the most you've ever used: Alcohol? _____ Drugs? _____

Have you ever had a time when you were drinking or using that you couldn't remember later? Yes No

of times this has happened? _____

Have you ever: Injected a Drug with a needle? Yes No Re-used or shared a needle: Yes No

If yes, explain: _____

Have you ever overdosed? Y N If yes, explain: _____

Why do/did you drink or use?: _____

Have you ever been to: AA? Y N NA? Y N If yes, explain: _____

Circle the People in your Family with a Current Or Previous Alcohol or Drug Problem:

Father Mother Step-Father Step-Mother Grandfather Grandmother
Brother Sister Uncle Aunt Spouse Child

What % of your friends: Drink: _____ % Use any drugs: _____ %

Circle all drugs you have ever used:

Alcohol Amphetamines Barbiturates Benzodiazepines Cocaine Designer Drugs
Inhalants Hallucinogens Marijuana Opiates Steroids Mini-Thins/Caffeine Pills

Explain any circles: _____

Do you use Nicotine? Yes No Type: _____ Amount per day: _____

Do you consider yourself to be an Alcoholic or an Addict? Yes No

Why or Why not? _____

Have you ever attempted suicide? Yes No Do you have current thought or plans of suicide? Yes No

Explain: _____

What Can I Expect? Counseling is a process of sharing with your therapist concerns, problems, ideas, questions, and decisions. The therapist will listen, share, question, challenge, confront, and support you to assist in determining how you will choose to handle the things that are troubling you. At Penrod Counseling Center, an added dimension to counseling is the willingness by your therapist to help you examine the spiritual dynamics of problems that exist and share Christ's healing for those problems. What you should expect from your counseling experience is that the therapist will help you think through problems, discover ways to deal with emotions and choices, and direct you to thoughts and resources that may help you with each solution.

Confidentiality: All counseling services provided are confidential. Exceptions to confidentiality include the release of information with client's signed permission, through court subpoena of records, or in the event of the therapist's knowledge of intended harm to self or others. The law requires that any case of sexual or physical abuse or neglect must be reported to Child Protective Services. If you have any questions concerning confidentiality, please discuss these with your therapist.

Fees: The fee charged for services is comparatively less than most private and state funded counseling services in this area. We have a sliding fee scale that will be used. Your therapist will establish a fee with you before sessions begin. Payment for all sessions is expected at the time of service. Late fees will accrue after 60 days of no payment. Also taking effect 11-15-03, there will be a \$5.00 fee for every payment not made at the time of service. This applies to groups and individual clients. Because our payments are among the lowest we will begin to send seriously delinquent accounts to a collection agency. Keep in mind that this would be a last resort and we do not wish this to happen to anyone!!! Seriously delinquent accounts are those that have no payments for six months.

At this time we do accept some types of insurance as a method of payment. All co-pays are due up front at the time of your appointment. You will be responsible for paying any residual fees attached to your counseling that the insurance company does not cover.

Charge For Missed Appointments: In order to plan our time and to make certain that we are available to those in need of services, we will bill for an appointment scheduled and not kept, unless canceled at least 24 hours in advance. The fee for those missed appointments will be your regular hourly fees, i.e., if you pay \$70 per session that will be your fee for missed appointments. *Insurance does not cover missed appointments.*

Note: There are risks and benefits involved with treatment; however, it is our goal to provide the most effective therapy possible. Clients have the right to withdraw consent for treatment at any time.

I have read and understand the above. _____ - _____



Penrod
Counseling
Center

“Treatment with Compassion”

317-272-5247

Fax: 272-1340

www.penrodcc.com

Offices: **Avon** - 6845 E US Hwy 36 Ste 440, Avon, IN 46123 **West** – 3410 N. High School Road, Indianapolis, IN 46224

Privacy Practices – HIPAA Information – Client Rights

I have received or reviewed the privacy practice notice for Penrod Counseling Center, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my mental health/addiction treatment records, and will use all due means to protect my privacy as required by Federal rule 42 CFR, Part 2 and summarized in the “Confidentiality of Alcohol and Drug Abuse Client Records.”. (See 42 U.S.C. 290dd-3 and U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal Regulations)

I have received or reviewed the statement of client rights for Penrod Counseling Center and was offered an oral explanation of these rights.

Patient Signature

Date

Print Patient Name



Penrod
Counseling
Center

“Treatment with Compassion”

317-272-5247

Fax: 272-1340

www.penrodcc.com

Offices: **Avon** - 6845 E US Hwy 36 Ste 440, Avon, IN 46123 **West** – 3410 N. High School Road, Indianapolis, IN 46224

Notice of Our Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information (IIHI)

Please review this notice carefully.

A. Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your IIHI. In conducting business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. Be federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. We may use and disclose your IIHI in the following ways.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as urine tests), and we may use the results to help us reach a diagnosis. Anyone who works for our practice may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse.
- 2. Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. We may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
- 3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. For example, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities.
- 4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
- 5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
- 6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
- 7. Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's IIHI.
- 8. Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. Use and Disclosure of Your IIHI in Certain Special Circumstances.

The following categories describe unique scenarios in which we may use or disclose your IIHI:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- * Maintaining vital records, such as births and deaths.
- * Reporting child abuse or neglect.
- * Preventing or controlling disease, injury or disability.
- * Notifying a person regarding a potential exposure to a communicable disease.
- * Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- * Reporting reactions to drugs or problems with products or devices.
- * Notifying individuals if a product or device they may be using has been recalled.
- * Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release for, signed by you with the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by law enforcement officials:

- * Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- * Concerning a death we believe has resulted from criminal conduct.
- * Regarding criminal conduct at our offices
- * In response to a warrant, summons, court order, subpoena or other legal process.
- * To identify/locate a suspect, material witness, fugitive or missing person.
- * In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to descendants and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the descendants.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosures for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

D. If You Have Questions About This Notice, Please Contact:

Penrod Counseling Center
192 N State Road 267, Ste 300
Avon, IN 46123



Client Rights

At Penrod Counseling Center..... You Have The Right:

1. To Mental Health Services which are...
 - a) In accordance with standards of professional practice
 - b) Appropriate to your individual needs
 - c) Designed to afford a reasonable opportunity to improve your condition.
2. To humane care and protection from harm.
3. To practice your own religion.
4. To receive a comprehensive, honest assessment of your mental health status and counseling needs (if any).
5. To appropriate, quality counseling that allows you to improve your situation at a reasonable cost, based on your family income.
6. To receive an appropriate referral when PCC cannot adequately meet your counseling needs.
7. To participate in the formation of your treatment plan and a regular (at least quarterly) review of your treatment and progress.
8. To ask that your treatment recommendation be reviewed by the entire PCC treatment team.
9. To confidentiality of your medical records except for the few instances built into Federal and State law.
10. To receive a copy of your medical records at a reasonable charge for photocopying and within a reasonably requested time frame.
11. To request to view the credentials of your therapist(s).
12. To view the national “Code of Ethics” governing our therapists and to expect that we abide by every ethical standard.
13. To contact and consult with legal counsel and private practitioners of your choice and at your expense.
14. To exercise your constitutional, statutory, and civil rights.
15. To receive services without discrimination based on your age, race, sex, religion, national origin, sexual orientation, income, or disability.
16. Against seclusion or restraint in our program.
17. To refuse treatment.
18. To information on the nature of treatment you might receive, the known effects of receiving and not receiving such treatment and information on alternative treatments, if any.
19. To a hearing of any grievances by the PCC Executive Director and, if you are not satisfied with that decision, to a hearing by the PCC Grievance Committee. If you are not satisfied with that decision, you have the right to report your complaint to the Indiana Family & Social Services Administration – Division of Mental Health, Consumer Service Line at 1-800-901-1133.
20. To receive a copy of the PCC program rules and expect that they be applied consistently.
21. To waive any of these rights voluntarily and to withdraw that waiver at any time; to receive admission to treatment regardless of if you waive any of these rights.
22. To exercise any of these rights without fear of retaliation.