

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	



PLEASE PRINT

CLIENT INFORMATION

Client's Name: (First Name) (Middle Name) (Last Name)

Address:

City: State: Zip:

Home Phone: Cell Phone: Social Security Number: Date of Birth:
May we leave a message at this number? No Yes

EMPLOYMENT INFORMATION

Are you currently employed? No Yes If YES, please provide the following information:

Employer Name: Employer's Address: City: State: Zip:

Work Phone: May we contact you at work? No Yes May we leave a message with your employer? No Yes

WHAT PROMPTED YOU TO SEEK COUNSELING? (Presenting Problems or Concerns)

[Large empty space for text entry]

REFERRAL INFORMATION

How did you hear about Childplace Counseling Services?

INSURANCE INFORMATION

Do you have insurance? No Yes If YES, please provide the following information:

WE MUST HAVE A PHOTOCOPY OF THE FRONT & BACK OF ALL INSURANCE CARDS (PRIVATE OR MEDICAID) *

PRIMARY INSURANCE COMPANY: _____

Member's Name: _____ Relationship to Client: _____

ID# _____ Group # _____

SECONDARY INSURANCE COMPANY: _____

Member's Name: _____ Relationship to Client: _____

ID# _____ Group # _____

****WE MUST BE NOTIFIED IMMEDIATELY ANY TIME A CHANGE IN INSURANCE COVERAGE OCCURS****

MEDICAL INFORMATION

Primary Care Physician:		Physician's Phone Number:	
Address:	City:	State:	Zip:
Please list any known allergies (food, medications, etc.):			
Please list any physical limitations, illnesses, or other information regarding overall health:			
Are you currently taking any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, please list ALL MEDICATIONS:			
Name of Medication:	Dosage/Frequency:	Name of doctor who prescribed medication:	
1. _____	_____	_____	
2. _____	_____	_____	
3. _____	_____	_____	
4. _____	_____	_____	
Pharmacy: _____	Location: _____	Phone: _____	

PAST COUNSELING AND/OR PSYCHIATRIC TREATMENT

Have you ever been hospitalized due to mental health/psychiatric reasons? No Yes

If YES, list name of hospital(s) and dates of hospitalization(s): _____

Have you ever received counseling or psychiatric care in the past? No Yes

If YES, list names of agencies, therapists, and doctors you have worked with: _____

IN CASE OF EMERGENCY (Physical or Mental Health) WHO SHOULD WE NOTIFY?

First Name:	Middle Name:	Last Name:	Relationship to Client:	
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Employer Phone:		

NO SHOW & CANCELLATION POLICY

We require 24 hours' advance notice to cancel or reschedule appointments. If an appointment is cancelled/rescheduled without 24 hours' advance notice, it is considered a LATE CANCEL. If a client does not show up for his/her appointment and does not call, it is considered a NO SHOW. If a client is more than 10 minutes late for an appointment, it is considered a LATE CANCEL, and a client will need to reschedule. IF A CLIENT HAS 3 NO SHOWS AND/OR LATE CANCELS within a 6 month period, he/she will be discharged from our care and the client's case will be closed. *Please initial: _____

ACKNOWLEDGEMENT

Your signature on this form indicates that you have read and understand all information presented.

Client's Signature

Date

Counseling Services

Consent For Treatment & Financial Responsibility Agreement

The below named client, guardian, or custodial agency hereby authorizes CHILDPLACE COUNSELING SERVICES to provide individual, group, family therapy, psychiatric treatment and support through the practitioners associated with Childplace, Inc., which include master's- level therapists, psychiatrist(s) and nurse practitioner(s).

The below named client, parent/guardian, or custodial agency hereby authorizes Dr. Mashiur Khan, MD, or other medical doctors/nurse practitioners associated with the counseling department to provide psychiatric services. These services include, but are not limited to, consultation/psychiatric support to the therapist overseeing treatment, an initial psychiatric evaluation and medication evaluation, and ongoing medication management for the client and thereafter if needed. (Note: A Client receiving ongoing medication management at Childplace is expected to meet at a minimum of 1X per month with his/her therapist.)

NO SHOW & CANCELLATION POLICY—24 hours' advance notice to cancel or reschedule an appointment is required. If an appointment is cancelled/rescheduled without 24 hours' advance notice, it is considered a LATE CANCEL. If a client does not show for his/her appointment and fails to call, it is considered a NO SHOW. If a client is more than 10 minutes late for an appointment, it is considered a LATE CANCEL, and client will need to reschedule. **IF A CLIENT HAS 3 NO SHOWS AND/OR LATE CANCELS within a 6 month period, he/she will be discharged from our care and the client's case will be closed.**

Childplace agrees to file Medicaid and other insurance claims on behalf of the client. The client is responsible for providing accurate insurance information to our billing department. The client is also responsible for providing any updated information to their insurance company, which may be needed to process claims. Copies of all insurance cards must be provided at the first scheduled visit.

The client, parent, or guardian is responsible for paying any insurance co-payments prior to services being rendered at each visit. **THE CLIENT, PARENT, GUARDIAN OR PLACING AGENCY IS RESPONSIBLE FOR PAYMENT OF SERVICES THAT ARE DENIED BY INSURANCE. CHILDPLACE WILL ACCEPT ASSIGNMENT FROM MEDICAID AS FULL PAYMENT OF THE CLIENT'S FEE FOR SERVICES.** If a client applying for Medicaid schedules appointments prior to receiving confirmation from Medicaid of active coverage, client will be responsible for full payment of services provided prior to the activation date determined by Medicaid. Client will also be responsible for payment of services rendered if the client was not eligible for Medicaid for any reason on the day the services were rendered. **IN CASES WHERE THERE IS NO INSURANCE COVERAGE, FULL PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED.**

Each insurance company has a different policy covering your medical costs—even within the same company the coverage and benefits vary. You are responsible for knowing the details of your coverage, including knowledge of covered and non-covered services. **IN ADDITION, YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS OR DEDUCTIBLE NOT COVERED BY YOUR INSURANCE.**

By signing below, I authorize release of information required by third party payer. I also authorize Childplace to receive direct payment and will act as their agent in helping to obtain payment from my third party payer, if a third party payer is involved. If my insurance company sends payment directly to my place of residence/home, instead of directly to Childplace, I understand that I am responsible for providing Childplace with this money for services rendered within 15 days of receiving the payment at my place of residence/home.

I have read and understand the information contained in this agreement and agree to my financial responsibilities as stated above, and I acknowledge by signing below that I consent for treatment to take place. This consent will remain in effect until the below listed client has been discharged as a client and is no longer under the care of Childplace Counseling Services. Or if the named client, or if client is a minor, the parent, guardian, or custodial agency revokes this consent for treatment in writing.

Client's Name (PLEASE PRINT)

Signature of Client, Parent, Guardian or Placing Agency Representative

Date

Relationship to Client or Custodial Agency



Client Rights (Counseling Services)

The client has the right to considerate and respectful care.

The client has the right not to be discriminated against. This right, however, does not include the potential denial of services when a client's diagnosis and/or issues may put Childplace staff and/or other Childplace clients at risk.

The client has the right to obtain from their practitioner complete and current information concerning the diagnosis, treatment, and prognosis in terms that he/she may be reasonably expected to understand. When it is not advisable to give such information to the client, the information should be made available to an appropriate person (medical proxy) on the client's behalf.

The client has the right to know the credentials and training of the staff responsible for his/her care.

The client has the right to expect Childplace Counseling Services to make reasonable responses to his/her requests.

The client has the right to the protection of the confidentiality of his/her relationship with Childplace staff, except when legal expectations or ethics dictate otherwise.

The client has the right to know that his/her health records will be treated as confidential material as stated in the HIPPA guidelines. Any disclosure to another party will be time limited and made with the full written, informed consent of the client, except when legal expectations—such as a court order—dictate otherwise. This right, however, does not exclude Childplace from providing requested information—such as diagnosis, prognosis, type of treatment, time and length of treatment, and cost—to secure third party payment.

A client may bring any concerns, comments, or ideas regarding his/her treatment to the practitioner with whom he/she is working.

If a client has problems or concerns that are not adequately addressed by his/her practitioner, the client may contact the Childplace Program Supervisor or Chief Operating Officer.

Client Name

Signature of Client, Parent or Guardian

Date



CHILDPLACE, INC. COUNSELING SERVICES

2420 East 10th Street Jeffersonville, IN 47130 812-282-8248 Fax: 812-206-8289

Protocols for Obtaining Medical/Mental Health Records, Treatment Summary Letters, and Services for Legal Purposes

Release of Information

Records may be released to another agency or physician via fax or mail upon signature of a Release of Information form. Records are released once the form has been signed by all adult participants. A fee of \$1 per page may be collected (cash only). Records are not released directly to clients, although clients may request a summary of treatment. Clients must schedule a session with their therapist to review records.

Treatment Summary Letter

Summary letters of treatment are \$50 per page for master-level clinicians and \$100 per page for a MD, Ph.D., or Psy.D. practitioner. The cost associated with a one-page report must be provided in cash to Childplace Counseling Services at a minimum of seven business days prior to date the report is needed. Balances for reports exceeding 1-page must be paid within 14 days.

Services for Legal Purposes

Services for legal purposes will be billed at \$100 per hour including travel time. This fee must be prepaid in cash to Childplace Counseling Services for 3 hours totaling \$300 at a minimum of 7 business days prior and is non-refundable. Balances for time over 3 hours must be paid within 14 days.

Verification of Treatment and/or Diagnosis

The cost associated with verification letters of treatment and/or diagnosis may be charged at a fee of \$15 per letter. (cash only)

***A \$25.00 fee to complete FMLA paperwork may apply.**

Your signature on this form indicates that you have read and agree to all information presented.

Signature (Parent or Guardian if under age 18)

Date



CONSENT TO RELEASE AND OBTAIN INFORMATION/RECORDS

Client's Name: _____ Date of Birth: _____
(First/Middle/Last) (Month/Day/Year)

I hereby authorize Childplace, Inc. to OBTAIN / RELEASE (please initial the one(s) that applies) the health/mental-health care information described below to/from the individual or entity listed here:

Name
Address
City/State/Zip Code
Phone Number

Note: this information must be completed at the time this form is dated and signed.

Given the information I have provided above, I understand that by checking the specific item(s) below, I authorize the following item(s) to be OBTAINED / RELEASED between Childplace, Inc. and the person or organization named above (please check all that apply):

- Intake Information, Verbal communication, Psychiatric Assessments, Initial Assessments, Treatment Plans, Psychosocial Assessment, Insurance Information, Admission Interview, Psychological Testing, Discharge Summary, Progress Summaries, Other, Psychological Testing Results/Report, Medication Information/History, School Records/Information/Testing, Alcohol/Drug Assessment, Alcohol/Drug Laboratory Results

The Purpose of Disclosure is to facilitate client's treatment and/or promote continuity of care.

I understand that the medical records released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne diseases, which are subject to federal and/or stated restriction on disclosure.

REDISCLASURE ACT: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit the receiver of this information from making any further disclosure of the same, except with the WRITTEN consent of the person to whom it pertains. A GENERAL AUTHORIZATION for the release of medical/psychiatric information is not sufficient for this purpose.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it, and I understand this consent expires automatically one year from the signature date below.

Client/Parent or Legal Guardian Signature Date

If the signature above is that of a parent or legal guardian, please provide the following:

Name (Printed) Relationship to the Client



LIMITS OF CONFIDENTIALITY

The contents of a counseling session, intake information, or an assessment are considered confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or the client’s guardian. EXCEPTIONS to this policy are as follows:

DUTY TO WARN AND PROTECT

When a client discloses to the therapist intentions or an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the client will use physical violence or use other means to cause serious personal injury or death to others, the therapist is required to warn the intended victim and or

victims and report the information to legal authorities.

ABUSE AND/OR NEGLECT OF A CHILD AND/OR VULNERABLE ADULT

If a client states or suggests that he or she is abusing or neglecting a child or a vulnerable adult or has recently abused or neglected a child or vulnerable adult or if a child or vulnerable adult is in danger or abuse or neglect, the therapist is required to report this information to the appropriate social service agency and or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

The therapist is required to report admitted prenatal exposure to controlled substances that are potentially harmful.

COURT ORDERS

Childplace Counseling Services and the therapist are required to release records of a client when a court order has been placed.

INSURANCE COMPANIES / MEDICAID

Insurance companies and/or Medicaid are provided with necessary information needed to file a claim. The information they request may consist of the following but is not limited to, the type of services rendered, dates and times of service, diagnosis, treatment plans, progress of therapy, case notes and summaries. Note: as of 1/1/07, Managed Care Companies that provide services on behalf of Indiana Medicaid require that mental health practitioners provide a client’s primary care physician with the following information: an overview of the initial assessment, including diagnosis, and treatment recommendations.

PSYCHIATRIC & CLINICAL SUPERVISION

Childplace Therapists will be consulting with our psychiatrist at times in regards to a client’s overall care, including but not limited to diagnosis, medication management, course of treatment, alcohol and drug related issues, and recommendations related to discharge.

Our masters level clinicians, which may include social workers and marriage and family therapists are required to participate in direct face-to-face clinical supervision as deemed appropriate by the state in which they are licensed until they have obtained the required number of supervisory hours. The clinician will be discussing cases with their direct supervisor in individual and group supervision on a regular basis. This information is kept in confidence with the exception of the above listed areas of concern.

Signature of Client or Guardian

Date



2420 East 10th Street
Jeffersonville, IN 47130
(812)282-8272

As a convenience to me, I authorize Childplace Family Services to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Childplace Family Services shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Childplace Family Services to me.

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that Childplace Family Services may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Childplace Family Services in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Placing my name in the field below acknowledges my authorization of electronic communication via text or email address on file with your office.

Email Address: _____

Client Name: _____

Client Signature: _____



Acknowledgement

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices.

Name of Child/Client

Signature of Child's Personal Representative/Client

Date



Would you like a copy of the notice for your records?

_____ YES

_____ NO