Community Counseling Center

CONFIDENTIAL CLIENT PAPERWORK

Today's Date: _____

Full Legal Name: _____

Preferred Name: _____ **Pronouns:** _____

Social Security Number: _____ **Date of Birth:** _____

Contact Information

Telephone(s): (H)_____ **(M)**_____

May CCC Staff leave a voice message? ☐ Yes ☐ No

If *Yes*, please specify: ☐ Home ☐ Mobile ☐ Work

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact – *please include your emergency contact in your release of information form.*

Contact Name: _____

Telephone(s): (H)_____ **(M)**_____

Relationship: _____

Referral Information – *what agency or person referred you to us.*

Agency (if applicable): _____

Contact Name: _____

Telephone(s): (W)_____ **(M)**_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Demographic Information – ***the questions below are for demographic/funding purposes only. Please mark the appropriate category.***

Race:

☐ American Indian/Alaskan Native ☐ Asian or Pacific Islander ☐ Black/African American

☐ White/Caucasian ☐ Multi-racial/Two or more races ☐ I prefer not to answer

Are you Hispanic, Latin, or of Spanish ethnicity? ☐ Yes ☐ No ☐ I prefer not to answer

If *Yes*, please answer the question below:

☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Central American ☐ South American

☐ Other: _____

How do you identify yourself?

☐ Female/Cis-Female ☐ Male/Cis-Male ☐ Nonbinary ☐ Trans-Female ☐ Trans-Male

☐I prefer not to answer ☐ Other: _____

Are you pregnant? ☐Yes ☐ No

What is your orientation?

☐ Heterosexual/Straight ☐ LGBTQIA+ ☐ I prefer not to answer

☐ Other: _____

Have you ever used drugs intravenously? ☐ Yes ☐ No

If *Yes*, when was the last time you used? _____

Have you ever been tested for HIV? ☐ Yes ☐ No

If YES, what was the result: _____

Financial/Insurance Information

Are you currently employed? ☐ Yes ☐ No

If *Yes*, what is the name of your employer? _____

Do you have health insurance/Medicaid? ☐ Yes ☐ No

If *Yes*, what carrier? _____

Insurance/Medicaid Member ID/Recipient Number: _____

Have you ever received services at this agency? ☐ Yes ☐ No

Are you receiving services somewhere else? ☐ Yes ☐ No

If *Yes*, what agency? _____

Intake/Client Concerns

The following information will assist us in recommending a treatment program that will best meet your needs. This is confidential information and will not be released without written consent. Please feel free to take your time in answering the following questions.

1. What services does your referral source wish you to receive from CCC?
   - ☐ Comprehensive Evaluation
   - ☐ Mental Health Assessment
   - ☐ Anger Management
   - ☐ Individual/One on One
   - ☐ NA/ Self-referred
   - ☐ Substance Abuse Assessment
   - ☐ Stress, Impulse Control
   - ☐ Recovery Group
   - ☐ Addiction Education

2. What services do *you* wish to receive from CCC?
   - ☐ Comprehensive Evaluation (Substance Abuse/Mental Health Assessment)
   - ☐ Stress, Impulse, Anger Management
   - ☐ Addiction Education
   - ☐ Marriage and Family/Couples
   - ☐ Recovery Group
   - ☐ Individual/One on One
   - ☐ HIV Education/Counseling
   - ☐ Affirmations: LGBTQ+ Affirmative Counseling provided at the Center by CCC.
   - ☐ Case Management (Do you need help with food stamps, transportation, applying for Medicaid, etc.)

3. What topics are you interested in exploring with a counselor?
   - ☐ Drug/Alcohol Concerns
   - ☐ Anxiety/Stress/Fear
   - ☐ Health Concerns
   - ☐ Other: _____
   - ☐ Depression
   - ☐ Job/Economic Concerns
   - ☐ Relationship issues

Comments - *Please list anything that you would like to address with a clinician or case manager. This form, like the rest of your file, is confidential and will only be used for treatment purposes.*

Community Counseling Center – Client Rights and Policies

These are universal rights and responsibilities for all clients attending any and all programs at our organization. Please take the time to read them. As the client of a program for treatment of abuse of/or dependence upon alcohol or other drugs, mental health, infectious disease, or any other program offered at CCC, your rights and responsibilities include, but are not limited to, the following:

- If the program received funds the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract that would be a hardship for you or your family.
- You have the right to treatment appropriate to your needs.
- If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
- You have the right to be informed of all program services which may be of benefit to your treatment.
- You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
- You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of the staff involved in your treatment.
- You have the right to be informed of your diagnosis, treatment plan, and prognosis.
- You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risk, the name of the person responsible for treatment, an estimate of the cost of the treatment, and a description of the alternatives to treatment.
- You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
- You have the right to examine your bill for treatment and to receive an explanation of the bill.
- You have the right to be informed of the program's rules for your conduct at the facility.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
- You have the right to receive respectful and considerate care.
- You have the right to receive continues care: To be informed of your appointments for treatment, the names of the program staff available for treatment, and of any need for continuing care.
- You have the right to make any reasonable request for services reasonably satisfied by the program, considering its ability to do so.
- You have the right to safe, healthy, and comfortable accommodations.
- You have the right to confidential treatment. This means that other than exceptions defined by law-such as those in which public safety takes priority-without your explicit to do so the program may release no information about you, including confirmation or denial that you are a patient.
- Waiver of any civil or other right protected by law cannot be required as a condition of program services.
- You have the right as a prospective client to be treated without any delay expressly based on age, disability, color, race, gender identity, religious orientation, sexual orientation, national origin, and/or ability to pay for services.
- Should you become a client, you further have a right to receive equitable treatment, not restricted in the employment of any advantage or privilege enjoyed by others under the program or with any aid, treatment, services, or other benefits which are different, or provide in a different manner from that provided to others under the program specifically based on age, disability, color, race, gender identity, religious orientation, sexual orientation, national origin, and/or ability to pay for services.
- You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.
- You have the right to attended religious activities of your choice, including visitation from a spiritual counselor to the extent that such activities do not conflict with program activities, the program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.
- You have the right to grieve actions, decisions of facility staff that you believe are inappropriate, including but not limited to actions, and decisions that you believe violate your rights as a client. The facility is obligated to develop a grievance procedure for timely resolutions of complaints from clients and to post such a procedure in a place

where it shall be immediately available to you. You have the right to freedom from retribution or other adverse consequences as the product of filing a grievance. Clients have the right to register grievance about his/her therapeutic treatment, the administration of rules, regulations, disciplinary measures, sanctions, and modifications of rights to the Chief Executive Officer. The Grievance Procedures form will be available at the front desk upon request. The Chief Executive Officer will investigate the grievance and will try to resolve the issue within ten (10) days of the complaint. If the issue cannot be resolved at the time, the Chief Executive Officer must inform the President of the Board who will then appoint a grievance committee, who will consider the issue and make recommendations to the Chief Executive Officer. Incident forms will be completed within 24 hours by staff. The Substance Abuse Prevention and Treatment Agency will be notified within 24 hours of any incident that may cause imminent danger to the health or safety of an employee of the agency, a client of the agency, or a visitor. This Agency will also be notified of notified of any report by a regulatory agency relating to Community Counseling Center, its physical plant, or its operations within 5 business days after Community Counseling Center's receipt of such report. Each step of transfer will be officially dated and documented by each recipient to substantiate continuity in guaranteeing the rights of the client. If the client still does not feel that his/her grievance has been resolved, he/she case to the Substance Abuse Preventions and Treatment Agency or Ryan White Part A depending under which program you are receiving services.

- You have the right to file a complaint to your satisfaction, and the right to freedom from retribution or adverse consequences as the result of filing a complaint. Such complaints may be addressed in writing or by telephone to:

Ryan White Part A Clark County Social Service 1600 Pinto Lane, Las Vegas, NV 89106 (702)455-4270	Substance Abuse Prevention and Treatment Agency Statewide Program Coordinator 4126 Technology Way, 2nd Floor, Carson City, NV 89706 (775) 684-4190
Office of the Attorney General Grants Unit 100 North Carson Street Carson City, Nevada 89701-4717 E-mail: dtanaka@ag.nv.gov Phone: (775) 684-1110 Fax: (775) 684-1102	U.S. Department of Justice Civil Rights Division 950 Pennsylvania Avenue, N.W. Washington, D.C. 20530 Hotline (English & Spanish): (888) 848-5306

- You have the right to receive a copy of the signed version of this form, Clients Rights, plus the signed Consent to Treatment and Confidentiality of Client Records Forms.
- You have the right to insert a written statement into your records.
- You have the right to be informed of your rights as a client. The foregoing is to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is possible upon your beginning treatment.
- You have the responsibility to comply with Community Counseling Center zero-tolerance policies prohibiting discrimination, harassment (including sexual harassment), violence, intimidation, weapons on premises (including licensed weapons), recording, and breach of confidentiality.
- You have the responsibility to set and keep appointments with your counselor. Let staff know as soon as possible if you cannot keep an appointment.
- You are expected to participate in all service decisions. You have the responsibility to help plan your goals. Follow through with agreed upon goals. Keep your counselor informed of your progress towards meeting your goals.
- Clients that are Self Pay are expected to pay their co-pay as has been determined by sliding fee scale established by the state of Nevada.
- You have the responsibility to terminate your counseling relationship before entering into arrangements with another counselor.

DISCHARGE CIRCUMSTANCES (criteria to be dismissed from the program)

- CCC will not tolerate harassment in any form.
- CCC will not tolerate abusive or threatening behavior to other clients, staff, or destruction of property.
- Excessive absences.
- Lack of attendance or contact after 30 days under the substance abuse treatment.
- Lack of attendance or contact after 90 days under any other program.
- Once the fee has been determined by the sliding fee process, refusal to pay may result in discharge from the program per state of Nevada Division of Mental Health & Developmental Services.
- Successful Completion constituting of completion all recommended treatment as well as achieved goals and objectives laid in treatment plan, paid financial balance in full or made arrangements with our financial officer (Self Pay clients), and, for mandated clients, a clean drug test is necessary to be discharged successfully.

IMPORTANT POLICY INFORMATION

- Community Counseling Center highly encourages clients to be actively involved in their treatment and to become aware of the changes necessary for the success of treatment.
- The counselor(s) will assess client's progress against treatment goals each month on whether or not clients are making necessary changes. If the counselor feels the client is not progressing the client will be informed and the client and his/her counselor will identify the changes necessary to successfully complete the program. If the client is not meeting the goals established, he/she may be recommended additional sessions until the counseling goals are met.
- Community Counseling Center considers successful treatment as indicated by the client showing obvious, observable, cognitive (mental) and behavior (action) changes or shifts and by demonstrating the ability to maintain those changes over time. We strive to support you throughout the process.
- Clients are expected to act in a manner that is respectful of other clients and their needs, as well as agency staff and agency property. If a client does not act accordingly, or becomes agitated or aggressive to the point that staff or clients feel threatened, Community Counseling staff may ask the client to leave the session and the premises. The agency does not engage in physical or chemical restraint, but clients refusing to leave the premises after being asked to will be removed by law enforcement officials.
- Community Counseling Center's substance abuse program is an abstinence-based treatment program; therefore abstinence is expected while attending our treatment program.
- Community Counseling Center is required by the State of Nevada to use a laboratory for urinalysis. The laboratory service reviews and reports on specimen results collected at our agency. Counselors may request random alcohol and drug tests when clients are referred here by the criminal justice system, child protective services, and other referral sources that are involved in the client's care. If a client is asked to provide a sample for a test, the results will be provided within 4 to 5 days. All standard alcohol and drug tests will cost $8.00 per test. In addition, the client will be responsible for any additional fees associated with the test. Please note that any positive drug test during treatment or at discharge will impact the client's treatment goals or impact whether or not the client is ready for discharge.

MANDATED PROGRAM POLICY STATEMENT

If you are accessing services under any of our mandated program (P&P, CPS, Courts, TANF or Welfare programs = if unsure, please ask the front desk for clarification).

- To ensure that Community Counseling Center is able to make appropriate reports on your behalf, you MUST provide court papers and documents. It is ESSENTIAL that these papers include:
    a. Name, address, phone number, and fax number of the judge, agency, P.O., and/or individual that would be considered the referral source.
    b. A return to court date and case number.
- Out of State cases that require a substantial amount of additional paperwork to be completed by the staff of Community Counseling Center and may incur additional fees.
- It is your responsibility to attend all sessions required. If you arrive at treatment 15 minutes late, may not be allowed to attend your session that day.

- This is an abstinence-based program, therefore if you exhibit symptoms of intoxication before or during group or individual sessions, he/she will be asked to take a drug/alcohol test at the cost of $8.00. If you decline such testing, it will be documented in your file and your referring agency may be informed. Additionally, you will not be allowed to attend a group or individual session that day. CCC also utilizes random testing and at any time a client may be asked to take a drug test (urinalysis).
- In ALL programs, if you do not attend treatment in a thirty (30) day period, you may be discharged from the program.

NOTICE OF PRIVACY PRACTICES - ***How we protect the confidentiality of your healthcare records.***

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

- What this notice does for you: This notice tells you the ways Community Counseling Center may use and disclose medical/treatment information about you. It also describes your rights in regard to this information, and it details certain obligations we have regarding the use and disclosure of this information. We are committed to protecting your confidentiality treatment information. Furthermore, we require by law to make every effort to ensure that any health information that identifies you in any way is kept private. We are also required to give you this Notice of Privacy Practices, and to make certain that the terms of the notice currently in effect are followed.
- Our Responsibilities: The following categories describe the different ways we use and disclose health information. For each category of use or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed, but the way we are permitted to use and disclose information will fall into one of these categories. Regardless of the category, we must obtain an authorization for any use or disclosure of psychotherapy notes except to carry out certain treatment, payment, or healthcare operations as noted below. Psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional that documented or analyze the contents of the conversation held during a private, group, joint, or family counseling sessions that are separated from the rest of the medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling sessions start and stop times, the modalities and frequencies of the treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.
- For Treatment: We may use medical information about you to provide you with medical treatment, care, or services. The originator of psychotherapy notes may use those notes for your treatment. We may disclose medical/treatment information about you to doctors, therapist, counselors, nurses, certified medical aids, technicians, students, consultants, contracted staff, or other center personnel who are involved in taking care of you at our facility. For example, if you are treated for depression, it may be necessary to know that you have been diagnosed with substance abuse because untreated substance abuse may impede recovery from depression. We may also disclose medical information about you to people outside the center who may be involved in your medical care, either while you are a client or after your course of treatment is completed. Examples of this may be physicians, other mental health and/or substance abuse professionals, or personnel from other agencies who partner with us in providing services that are part of your care. If you would like us to share information regarding your health/treatment status with your family members, you will be given the opportunity to sign an authorization permitting us to do so. If you choose not to sign this, information will not be given without a legal consent for the requesting party to obtain it, unless the appropriate authorization is received from you prior to the request.
- For Payment: We may use and disclose health information about you so that the treatment and services you receive at Community Counseling Center may be billed to and payment collected from you, a government payer, or third party. For example, we may need to give your health plan, Medicaid, or Medicare information about the services you received at our center so we will be paid for these services. We also may tell Medicaid, Medicare, or your health plan about a treatment modality you are going to receive to obtain prior authorization for that treatment. If the services you are receiving are provided under a federal or private grant, we may provide the agency disbursing those funds for that grant with information about the services you have received so the grant funds may be properly dispersed an applied.
- For Operations: We may use and disclose information about you and the services you receive at our center for operations. These uses and disclosures are necessary to run the center and make sure that our clients receive quality care. For example, we may use treatment information to review our care and services and to evaluate the performance of our staff caring for you. We may use or disclose psychotherapy notes to our own training programs

in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling. We may also combine treatment information about many clients to decide what additional services the center should offer, what services are not needed, and whether certain new services are warranted. We may remove information so others may use it to study mental health care and substance abuse treatment, and the treatment delivery system, without learning who the specific clients are.

- For Service Alternatives: We may use and disclose medical/treatment information to tell you about or recommend service options or alternatives that may be of interest to you.
- Health Related Benefits and Services: We may use and disclose medical/treatment information to tell your health-related benefits or services that may of interest to you.
- Individuals Involved in Your Care or Payment for Your Care: We may release treatment information about you to a friend or family member who is involved in your care, but only with your authorization. Nevada State law (NRS 49.209 and NRS 49.247) establishes the "general rule of privilege" by which we are bound.
- As Required by Law: We will disclose medical/treatment information about you when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety: We may use or disclose medical/treatment information about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- Military Command Authorities: We may use or disclose medical/treatment information about you as required by military command authorities. We may also release medical/treatment information about foreign military personnel to the appropriate foreign military authority.
- Workers' Compensation: We may release medical/treatment information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- Public Health Risks: We may disclose medical information about you for public health activities. These activities include the following:
    - To prevent or control disease, jury, or disability.
    - To report deaths.
    - To report reactions to medications or problems with products.
    - To notify people of recalls or products they may be using.
    - To notify a person who may have been exposed to a disease or may risk contacting or spreading a disease or conditions.
    - To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence in any form. We will only make this disclosure if you agree when required or authorized by law.
- Coroner, Medical Examiners, and Funeral Directors: We may disclose health information to such entities consistent with applicable law to carry out their duties.
- Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your treatment information.

HEALTH INFORMATION RIGHTS - You have the following rights regarding medical/treatment information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make a decision about your treatment. Usually this includes medical billing records, but may not include psychotherapy notes, as per 45 CFR 164.524. We may deny your request to inspect and copy in certain limited circumstances. In some instances, you may request that this denial be reviewed. Another licensed health care professional chosen by the center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the reviewer's decision.
- Right to Amend: If you feel that health information, we have about you is incorrect or incomplete, you may ask us to amend that information, as per 45 CFR 164.528.
- Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information, as per 45 CFR 164.528.
- Right to Request Restrictions: You have the right to request restrictions or limitations on certain uses and disclosures of your information as provided by 45 CFR 164.522.

- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical/treatment 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 in writing to the Administrator or the Health information Management Coordinator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to Paper Copy of this Notice: You have the right to a paper copy of this notice, even if you have agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, ask any Community Counseling Center employee.
- Other Uses of Your Health Information not covered by this notice or laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose information about you, you may revoke that permission in writing at any time. If you revoke permission, we will no longer use or disclose information about you for the reasons covered by you own written authorization.
- You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our record of the care that we provided to you. Community Counseling Center retains electronic client records in a confidential, secure EHR.
- Changes to this Notice: We reserve the right to change to the contents of this notice. We reserve the right to make the revised or changed notice effective for medical/treatment information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the center.
- Complaints: If you believe your privacy rights have been violated, you may file complaints with the Community Counseling Center Privacy Point of Contact or with the Secretary of the Department of Health and Human Services. To file a complaint with this center, contact the Privacy Point of Contact. All Complaints must be submitted in writing. You may obtain a complaint form from any employee.

You will not be penalized for filing a complaint. The effective date of this notice is April 14, 2003.

BUREAU OF HEALTH REGULATIONS POLICY

CCC does not deny or delay treatment of a prospective client on the grounds of handicap, race, gender, religious beliefs, sexual orientation, gender identity, national origin, and/or ability to pay for services. No client shall be given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or with any aid, treatment, services, or other benefits which are different, or provided in a different manner from that provided to others under the program, on the grounds of handicap, race, gender, religious belief, sexual orientation, gender identity, national origin, and/or ability to pay for services.

FEE DETERMINATION POLICY AND FINANCIAL INFORMATION

The following information is protected under the confidentiality regulations of HIPAA and 42 CFR.

- You may be eligible for a determination of fees according to a sliding fee schedule that is contingent upon your providing verifying information. Such documentation should be provided at the intake session at which your share of costs is determined. If a client cannot provide proof of income, or if a client is indigent/homeless, we require a signed, written statement as proof of such. If a client qualifies for the sliding fee scale, then his/her session fees will be lowered appropriately. If you are not able to pay the full amount of the evaluation fee at this time, you may make payment arrangements with authorized staff. If you qualify for Medicaid, you are not eligible for the sliding scale. Sliding scale qualified individuals include but are not limited to mandated clients outside of Medicaid/insurance session limits, undocumented aliens, and those individuals pending Medicaid. Client fees for those who are not eligible for the SAPTA sliding scale are based on the current full fees and unit cost.
- To qualify for the Sliding Fee Scale, you **MUST** bring in proof of income documentation for **ALL** income you and any members of your household may receive. Examples of this documentation include W-2 forms, tax returns, last two check stubs, bank statements, letters of I understand and accept Community Counseling Center's fee determination policies. I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.
- Please read carefully:
    - Once the fee has been determined by the above process, refusal to pay may result in discharge from the program per state of Nevada Division of Mental Health & Developmental Services.

- A twenty-five ($25.00) dollar non-sufficient fund (NSF) fee will be charged for checks initially returned unpaid by your bank. If the same check is returned unpaid a second time it may be referred to a collection service for recovery.
- We do not accept out-of-state checks or checks for final payment of your bill.

CONSENT TO TREATMENT

As a client of Community Counseling Center, I understand that:

- I am entitled to treatment and rehabilitative care to include referrals to appropriate psychological and training services, as part of my treatment plan.
- I have the right to refuse any or all parts of my treatment plan, with the exception of emergency treatment.
- Consent to any or all parts of the treatment plan may be withdrawn at any time.
- I will be informed of the nature, consequences and purpose of the treatment plan, and any alternative plans and resources available.
- All counseling sessions are confidential, but I understand that my counselor is obligated by law to inform appropriate parties if I am in danger or if I am causing danger to someone else.
- Admission to this program does not include granting Power of Attorney to the operator or employees of the program.
- Community Counseling Center is an approved internship site, which utilizes interns to assess, diagnose, and treat its clients under strict supervision. By signing below, I hereby consent and acknowledge that an intern may conduct my counseling sessions at Community Counseling Center.
- Although I may be assigned a certain number of counseling sessions at the start of my treatment, completing this number of sessions does not necessarily mean that I have successfully completed my treatment. If I have not met my treatment goals, additional sessions may be recommended by my counselor.
- As a client of Community Counseling Center, I have read my rights and acknowledge receipt of a copy of Client Rights.
- I understand that successful treatment is demonstrated by mental and behavioral changes sustained over time. I will have a regular opportunity to discuss with my primary therapist my progress (or lack of progress) toward meeting these goals.
- I have been fully informed of the above, understand the process and my responsibilities as a client receiving treatment, and agree to accept such treatment and to cooperate in its implementation.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS - 42 U.S.C. 290ee for federal laws & 42 CFR Part 2 for federal regulations

The confidentiality of alcohol and drug client records, maintained by this program (Community Counseling Center), is protected by federal law and regulations. Generally, the program, staff, volunteers, or contractual personnel may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuser.

- Unless:
  - The client consents in writing.
  - The disclosure is allowed by a court order, or
  - The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.
  - The client commits or threatens to commit a crime on program premises, or against program staff.
- Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.
- Federal law and regulations do not protect information about a crime committed by a client, either on the premises or against any program staff, or about any threat to commit such a crime.

- Federal law and regulations do not protect information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.
- Federal law and regulations prohibit the re-disclosure of protected information by the disclosure.

CLIENT DRESS CODE - serves to provide guidelines for clients' dress and appearance.

Clients are to be dressed in such a manner that their appearance at the agency contributes to the therapeutic environment. Exemption from the CCC Basic Dress Code may be permitted for medical or religious reasons with counselor approval.

- Require the correct wearing of face masks for on-site services.
- Require the wearing of footwear with soles for on-site services.
- All clothing must be sufficient to conceal any and all undergarments. No skin will show between the bottom of shirt/blouse and top of pants or skirts at any time. All sleeveless shirts must have straps. Prohibited tops include, but are not limited to, crop tops, strapless, low-cut clothing, clothing with slits, or tops and outfits that provide minimum coverage.
- Require that all shorts, skorts, skirts, and jumpers/dresses must be at least at fingertip length for onsite services.
- All jeans, pants, and shorts must be secured at waist level. Sagging is prohibited. Jeans, pants, and shorts are not to have rips or tears that expose undergarments and/or are located mid-thigh or higher for onsite services.
- Slogans or advertising on clothing, jewelry, buttons, and/or accessories which by their controversial, discriminatory, profane, and/or obscene nature disrupt the therapeutic setting are prohibited.
- Any clothing, jewelry, buttons, and/or accessories that promote illegal or violent conduct, or affiliation with groups that promote illegal or violent conduct such as, but not limited to, the unlawful use of weapons, drugs, alcohol, tobacco, or drug paraphernalia, or clothing that contains threats are prohibited.
- Clothing may not, at any time, be used to conceal weapons, drugs, or other related paraphernalia.

** What constitutes a violation of these guidelines may be subject to the discretion of the staff of Community Counseling Center. CCC reserves the right to request that a client wearing inappropriate attire change his/her clothing, obtain an appropriate garment from the agency Resource Room, or be asked to leave and make up the missed appointment later.*

TELEHEALTH/TELECOUNSELING POLICIES AND ACKNOWLEDGEMENT

- I understand that my counselor and/or administrative staff, has recommended to me that I engage in a Telecounseling/Telehealth appointment with Community Counseling Center/CCC.
- My counselor and/or administrative staff has explained to me how telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct client/counseling/case management visit due to the fact that I will not be in the same room as my Community Counseling Center provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
- I understand that my counseling and case management information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my CCC provider and specialty health care provider in order to operate the equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my counseling that are personally sensitive to me; (2) ask non-clinical staff personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.
- In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.
- I understand that billing for the telehealth consultation may occur from 1) the CCC provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

- I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Appointment Reminders and Other Healthcare Communications

As a client in our practice, you may be contacted via telephone, email and/or text messaging by CCC staff for various reasons as follows:

- To remind you of an appointment – via phone call and/or approved voicemail message.
- To remind you of an appointment – via automated text message or email.
- To obtain feedback on your experience with our healthcare team via telephone.
- To provide general health information via telephone or email.
- CCC may also communicate via social media private messages under the following circumstances:
    - The private message is either initiated by the client or is the only means of communication with the client.
    - No confidential information is discussed.
- I understand that I might receive appointment reminders and other healthcare communications/ information from Community Counseling Center.
- I also understand that I might receive text messages, which may incur charges in accordance with my cell phone data plan, at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.

Client Acknowledgement(s)

Client Name: _____ **Date of Birth:** _____

The cell phone number/email(s) that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is:

_____ & _____

By signing this form, I acknowledge I have or will be receiving a copy of the following documents:

- CLIENT RIGHTS AND RESPONSIBILITIES
- MANDATED CLIENT POLICIES
- HEALTH INFORMATION RIGHTS
- CONSENT TO TREAT
- CLIENT DRESS CODE
- IMPORTANT POLICY INFORMATION
- NOTICE OF PRIVACY PRACTICES (HIPAA)
- FEE DETERMINATION POLICY/FINANCIAL INFORMATION
- CONFIDENTIALITY OF ALCOHOL/DRUG ABUSE CLIENT RECORDS
- TELEHEALTH/TELECOUNSELING POLICIES
- A copy of a/all consent(s) to release information.
- A copy of CCC's treatment recommendations.

By signing this form, I acknowledge that I have received and read the following policies and consents:

- I acknowledge that I have read and understand this form pertaining to Community Counseling Center's Important Policy Information.
- I acknowledge that I have read and understand this form pertaining to Community Counseling Center's Mandated Program Policy Statement.
- I acknowledge that I have read and understand this form pertaining to Community Counseling Center's Fee Determination Policy. I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.
- I acknowledge that I understand that Community Counseling Center does not deny or delay treatment to a prospective client on the grounds of handicap, race, gender, religious beliefs, sexual orientation, gender identity, national origin, and/or ability to pay for services. No client shall be given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or with aid, treatment, services, or other benefits which are different, or provided in a different manner from that provided to others under the program, on the groups of handicap, race, gender, religious beliefs, sexual orientation, gender identity, national origin, and/or ability to pay for services.
- I understand that I may be asked to submit to random UAs (urinalysis) or breathalyzer testing and that I am responsible for the cost(s) associated with these tests.
- I consent to receive text messages and emails, to receive communications as necessary from Community Counseling Center.
- I certify that I will furnish all insurance cards/paperwork and financial documentation as requested by Community Counseling Center including Identification (Driver's License, State ID, Clarity Card, etc.), Insurance Card(s), and Documentation of Household Income (Tax Returns, W2 for all household members, check stubs for all household members, etc.)
- This page serves as acknowledgement of my signature will be kept on file for future clinical records such as treatment/service plans, progress notes, etc., for so long as I give consent (written or verbal) to CCC clinicians/staff to record my signature as such.

Client Signature: _____

Parent/Guardian Signature (if applicable): _____

Date: _____

Community Counseling Center – General Release of Information:

Client Name: _____ **Date of Birth:** _____

I authorize Community Counseling Center (CCC) to disclose and/or obtain records and information pertaining to my mental health and/or substance use treatment for the purposes of care coordination, billing/payment, justice system/referral reporting, or healthcare operations to the following:

_____

Name of organization/entity to whom information is being disclosed (ex: Parole Officer, Emergency Contact, Office of Attorney)

Contact Information of Disclosee:

Name: _____

Telephone #: _____ **Fax #:** _____

Information to be disclosed:

- ☐ **Comprehensive Evaluation**
- ☐ **Treatment Recommendations**
- ☐ **Laboratory Results**
- ☐ **Treatment Plans**
- ☐ **Care Coordination**
- ☐ **Progress/Discharge Reports (compliance w/attendance, diagnosis, participation, financial)**
- ☐ **Discharge Summary/Plans**
- ☐ **Completion Certificates**

I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification to my therapist at Community Counseling Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization expires one year from the date that it is signed. I further understand that Community Counseling Center will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may result in Community Counseling Center's inability to effectively communicate to referral/mandated sources and/or other persons/entities on my behalf. Unless specifically requested in writing that the disclosure be made in a certain format, CCC reserves the right to disclose information as permitted by this authorization in any manner that deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records, 42 CFR part 2, as well as federal HIPAA regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as noted above. I will be given a copy of this authorization for my records.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

CCC Staff: _____ **Date:** _____

Statement to disclosee: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2 & HIPAA). The federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by written consent of the person to whom it pertains.