



# Valliere & Counseling Associates, Inc.

Forensic Treatment Services

## CLIENT INTAKE INFORMATION

### Evaluation

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK: \_\_\_\_\_

**At what number may we leave a message?** Check all. ( ) home/cell ( ) work

REFERRAL SOURCE: \_\_\_\_\_

PRESENTING PROBLEM: \_\_\_\_\_

*Please specify the following. It is important to note that email is not a highly secure form of communication. Generally, we will not use email as a regular form of communication without your authorization. We cannot ensure who sees your email, though we have taken reasonable measures to assure our security and privacy. If you choose to communicate with us by email, please be aware of the risks to your own confidentiality.*

**Who may we contact in case of emergency or speak to regarding your appointment? We will never share other confidential information without your written consent.**

EMERGENCY CONTACT: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Do you want us to use your email for scheduling or other administrative purposes?**

\_\_\_\_\_ No, I do not give permission to be contacted by email.

\_\_\_\_\_ Yes, you may contact me by email. Email: \_\_\_\_\_

Is there a custody agreement? Yes / No      If yes, please explain: (shared/sole,legal/physical)

I, the undersigned, hereby authorize Valliere & Counseling Associates to release any information necessary to facilitate payment of services rendered. I understand I am financially responsible for all charges whether or not I am reimbursed by insurance. If I receive monies from my insurance company for the charges I am responsible to use these funds to pay my bill. Failure to pay for services rendered may result in the use of a collections agency to collect fees. If Valliere & Counseling Associates is unable to collect payment for services rendered and must use a collection agency, I will be responsible for all collection and attorney's fees accrued. A photocopy of this authorization shall be considered effective and valid. I authorize the use of this signature for all insurance forms.

Signature: \_\_\_\_\_

**Confidential**

MEDICAL HISTORY

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

Please list medication and any current medical problems: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Family History: Please list family member and any known diseases / illness / medical problems.  
 If deceased, please list age at death and cause.

Biological Father: \_\_\_\_\_  
 Biological Mother: \_\_\_\_\_  
 Siblings: \_\_\_\_\_  
 Children: \_\_\_\_\_  
 Spouse: \_\_\_\_\_  
 Grandparents: \_\_\_\_\_  
 Other: \_\_\_\_\_

Personal History: Please list any of the following:

Caffeine Use: \_\_\_\_\_  
 Nicotine Use: \_\_\_\_\_  
 Alcohol Use: \_\_\_\_\_  
 Surgeries: \_\_\_\_\_  
 Illnesses: \_\_\_\_\_  
 Significant Injuries: \_\_\_\_\_  
 Hospitalizations: \_\_\_\_\_

Have you experienced any of the following?

Seizures/Convulsions?	Yes	No	Current	Diabetes?	Yes	No	Current
Heart Problems?	Yes	No	Current	Panic Attacks?	Yes	No	Current
Migraines? Strokes?	Yes	No	Current	Flashbacks?	Yes	No	Current
	Yes	No	Current	Memory Loss?	Yes	No	Current
High Blood Pressure?	Yes	No	Current	Depression?	Yes	No	Current
Tuberculosis? Nervous	Yes	No	Current	Violence?	Yes	No	Current
Breakdown Suicide	Yes	No	Current	Asthma?	Yes	No	Current
Attempts? Thyroid	Yes	No	Current	Anxiety?	Yes	No	Current
Problems?	Yes	No	Current	Arthritis?	Yes	No	Current
Sleeping Difficulties?	Yes	No	Current	Cancer? Chest	Yes	No	Current
Premenstrual Problems?	Yes	No	Current	Pain?	Yes	No	Current
Appetite Change?	Yes	No	Current				
Loss of Sexual Desire?	Yes	No	Current				

**Confidential**CLIENT RIGHTS AND RESPONSIBILITIES

I agree that I have participated in the evaluation voluntarily and can voluntarily terminate my participation. I agree that I am able to expect ethical and competent treatment, but have not been promised a cure or definitive relief from my symptoms.

I understand that evaluation relies on my cooperation, honesty, and motivation. This evaluation is limited by any dishonesty, omissions, incorrect or inaccurate information provided by me and or in my records.

This evaluation will be distributed only to the referral agency, the Court, or relevant parties with the appropriate consents. If an agency has paid for my evaluation, that evaluation is owned by that agency and cannot be disseminated by this agency. If you have paid for your evaluation, you can be provided a copy *if the evaluation does not contain information that could psychologically damage me*. If that is the case, the evaluator will meet with you to review the evaluation, information, and conclusions within the report.

I understand that my treatment may be terminated involuntarily for the failure to show for 2 or more appointments or no contact within 21 days; violent or threatening behavior; continued or progressive substance use; or breach of confidentiality. I may also be discharged if my evaluator and I determine I am not amenable or am uncooperative. I will be notified of my termination from treatment.

I have a right to be referred if the agency cannot adequately meet my needs. I can expect to be scheduled in a manner that attempts to address my scheduling limitations as well as the availability of staff. I have been informed of the legal limits of confidentiality. I understand I will be involved with my treatment planning and expectations for completion of my treatment. I understand that Valliere & Counseling Associates, Inc. does not discriminate based solely on age, race, color, ethnicity, marital status, religion, sexual orientation, handicap, sex, creed, or political affiliation. I will not be deprived or my civil rights solely by reason of treatment (PA State Law Act 71, Sect. 7 - PS1690.107).

I have the right to inspect my records, as well. If I request to inspect my records, the counselor/director has the right to temporarily remove material or limit my access if it is felt that information may be harmful to me. I have the right to appeal this decision in writing. I also have the right to request that outdated, irrelevant, incomplete, or inaccurate data be removed from my file or corrected. I have the right to add my own rebuttal or memoranda to my file regarding information within.

I have read and understood my client rights.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### **INFORMED CONSENT FOR EVALUATION**

This consent is to insure your understanding of the nature of your EVALUATION. You have been court-ordered or Agency mandated to attend EVALUATION. The services you are receiving have been requested by the Court or your referral agency. You may have been ordered to participate to help determine your treatment needs, answer questions regarding your child or factors influencing your child's care, determine your level of emotional and psychological functioning, and/or to assist the Court or referral agency in assessing your suitability as a caregiver. It is important that you understand that the services provided may have an influence over the Court's or Agency's decision making in your or your family's regard. Your signature indicates that you are aware of the potential influence of these services and that you, if applicable, have discussed these issues with your attorney.

Because you are court ordered/mandated to participate in this service, the Court may require the professionals involved with your care to appear in court or a hearing or provide documentation for court on your progress. The professional's appearance in court may be to summarize findings, provide diagnostic issues, make recommendations, and in other ways, give the Court or Agency relevant information regarding the referral issues. The staff will never seek to embarrass, humiliate, or expose you. Information relevant only to the referral questions will be shared. However, it is important to understand that you may be uncomfortable or unhappy regarding the information that is shared. As much as possible, the professionals involved in your care will ensure that you are prepared for what is to be discussed in court or reported to your Agency. Your signature indicates that you understand that the professionals involved in your care may appear in court and provide information to the referring Agency.

Despite the fact that the Court or Agency has mandated your care, this service is still considered voluntary by FTS. This means that you always have the freedom to end your relationship with FTS or stop any evaluation. In doing so, you assume all responsibility for any consequences of your failure to participate. Additionally, if you choose not to follow the rules or expectations of my treatment, or fail to make progress or cooperate, you may be discharged from the program. FTS assumes no responsibility in attempting to keep you in treatment, nor do they assume responsibility for possible consequences that your discharge may hold for you.

**By signing this form, you acknowledge you have and are able to provide informed consent to these services:**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Confidential**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION  
TO PRIMARY CARE PHYSICIAN

In order to best facilitate coordination of your care, your therapist or counselor may need to communicate with your primary care physician (PCP). This form will allow your treatment professional to exchange information with your PCP as outlined in this release. The information exchanged may include diagnosis, treatment plan, progress, and medication if necessary.

I, \_\_\_\_\_, (DOB: \_\_\_ / \_\_\_ / \_\_\_), authorize my treatment professional from *Valliere & Counseling Associates, Inc.* to release protected health information related to my evaluation and treatment to:

Primary Care Physician: \_\_\_\_\_

PCP Phone: \_\_\_\_\_ PCP Fax: \_\_\_\_\_

PCP Address: \_\_\_\_\_

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\_\_\_\_\_ was seen at this office for symptoms of \_\_\_\_\_

\_\_\_\_\_

If you have any questions, please call Valliere & Counseling Associates at (610) 530-8392.

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**Patient Rights**

- You can end this authorization at any time in writing to this office.
- You cannot be required to release information as a condition of treatment, payment, enrollment or eligibility for payments.
- Information that is disclosed as a result of this form may be re-disclosed and is not protected by law.
- You do not have to agree to this request to use or disclose your information.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire 1 year from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

\_\_\_\_\_ To release any applicable mental health/substance abuse information to my PCP.

\_\_\_\_\_ I DO NOT give my authorization to release any information to my PCP.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

All information released will be handled confidentially, in compliance with the Federal Regulation 42 C.F.R., 2.31 and 2.35, and 4 PA Code 255.5, PA Act 143. Information from other facilities, persons, organizations provided will not be re – released to fulfill requests within this consent, unless expressly permitted (42 CRF Part 2). A general authorization is not sufficient.

**Confidential**LIMITS TO CONFIDENTIALITY & PRIVACY POLICY (HIPAA)

I understand that I have the right to confidentiality regarding my treatment. Any information that is released, I have given specific written consent to release and can revoke that consent in writing. This release shall specify the type of information released specifically, the purpose of the release, the time limits of the release, and to whom the release is for. These releases shall be maintained in my file and the information released shall be noted.

I understand that it may be necessary, as a condition of treatment, to release information to my referral agency or the court to document my compliance and progress in the program. Otherwise, my treatment is completely confidential to any outside source without specific written consent. In certain situations, I may give temporary verbal permission for the release of some information, however, this is the exception.

I understand that Valliere & Counseling Associates, Inc./Forensic Treatment Services follows the laws regarding HIPAA and makes reasonable efforts to ensure that my protected health information (PHI) is not shared electronically in violation of the law. Information that is shared electronically is shared in accordance with the HIPAA rules.

*Treatment Team*

I understand that Forensic Treatment Services/Valliere & Counseling Associates, Inc. is an agency that works as a team for my care. I am likely to have multiple therapists and the treatment team makes collaborative decisions on my care. In order to follow the team approach, I understand my information will be shared among clinicians within the agency of Valliere & Counseling Associates, Inc. The administrative staff will also have access to my protected information for the purposes of billing, scheduling, and other administrative duties. Clinical information is not generally shared with administrative staff, but used for clinical decision-making. All the staff is bound by the same rules and laws regarding your confidentiality and privacy under HIPAA.

*Business Associates*

HIPAA also binds any business associates that might come in contact with your information as well. This would include any billing agencies or accounting that would be involved in transmitting information for purposes of reimbursement. If you are court or criminal justice involved, you might not have the same rights of privacy under HIPAA regarding information about your compliance in the criminal justice system. However, we will always attain a specific release of information from you for any agency we communicate with, regardless of the requirements under HIPAA.

*Limits to Confidentiality/HIPAA*

There are some legal limits to confidentiality that I have been informed of and understand. These limits are mandated by law and my treating professionals are mandated reporters. These situations require that my counselor report information that I disclose to official agencies that may include, but are not limited to, child abuse reporting hotlines, crisis intervention lines, police, or Children and Youth Services. The following situations may require a breach of my confidentiality:

1. Disclosure of information regarding a child that I have physically or sexually abused;
2. Disclosure of a threat to harm myself or an identifiable party, or a general threat to harm that the staff assesses as dangerous. The staff must take action to protect you or the party threatened including:
  - a. Informing the person or guardian of the person threatened;
  - b. Calling crisis intervention;

**Confidential**

- c. Notifying legal authorities, including the police or probation/parole officer;
- d. Notifying agencies able to inform or protect the party threatened.
3. Display of high risk behavior that warrants intervention and requires protection of myself or the community;
4. Criminal or threatening behavior on the facility property or towards staff;
5. Medical emergencies occurring in the facility.

Only information necessary to ensure that steps are taken for intervention will be revealed. I also know that I may forfeit confidentiality if committing a crime against or initiating a lawsuit against the staff or the agency. Legal action or complaints against the agency might entail a release of my entire record for review. I understand that the agency might be required to allow a review of my record to a government agency in certain situations. Also, I understand that there might be situation where information in my file that completely removes my identity or protected information could be used for research or data collection.

*Funding/Use of Insurance/Payment*

If I am receiving funding from an agency, insurance company, contract, or state/Federal/County source, I give consent for the necessary information to be released regarding my treatment and diagnosis to facilitate payment of my treatment. I understand that this generally includes only attendance, services received, a diagnosis code (if applicable), and an identifying number (e.g. DOC number). I can prohibit this information to be released, but will not receive funding for my care. I also understand that to receive this funding, my file may be audited by the funder to insure compliance with a contract. This is required to receive funding and all auditors will sign a confidentiality agreement with the treatment facility.

If I chose to use medical insurance to pay for my treatment, I understand the following:

1. The insurers will/can be provided a diagnosis, type and frequency of treatment, charge, intervention used, and response to treatment for purposes of payment. There might be a situation where the insurer requests a treatment plan or reviews your file.
2. The insurers will have access to my diagnosis and my treatment must reflect treatment of that diagnosis. Some diagnoses are not reimbursable because treatment for them is not considered medically necessary.
3. I will be given an accurate diagnosis related to my treatment. While I might have other conditions that are secondary to the treatment reason, my primary diagnosis is related to treatment.
4. I can refuse to release this information and therefor forgo funding for my treatment and am completely responsible for all fees.
5. I understand that Valliere & Counseling Associates, Inc./Forensic Treatment Services has no ability to control how the insurance company protects the information received, including using it for redisclosure.
6. I understand that Valliere & Counseling Associates, Inc./Forensic Treatment Services will be required to release certain information if I chose to file a Worker's Comp or auto/injury insurance claim related to issues addressed in treatment. This might require some release of information to my employer.

If I fail to pay my fees and have an outstanding balance that I have not addressed for more than 60 days, the agency has the right to utilize a collection agency. I understand that this will require some release of protected information and that my signature on this document acknowledges such. I will be responsible for any fees required to collect the monies due, as well.

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### *Clinical Record*

HIPAA affords me certain rights under the law regarding my record. I am aware that there are two types of records, one that contains my clinical record, which includes information about my reasons for seeking therapy, a description of the ways in which my problem impacts on my life, my diagnosis, the goals that we set for treatment, my progress towards those goals, my medical and social history, my treatment history, any past treatment records that the agency receives from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to my insurance carrier.

It should be noted that I might be receiving services as part of a criminal proceeding or court mandate. In that case, my file is considered differently and might hold details about my crime or criminal behavior, as well as factors related to my risk to the community or potential for re-offense. In forensic therapy, the goal is supervision and management, as well as protection of the community, which requires different record keeping and more detail than is regularly kept in a clinical record. Also, if I am receiving services mandated by an agency such as Children and Youth Services, there might be details about my disclosures that are of investigative interest.

My record might also include psychotherapy notes, which are not kept with the clinical record. These notes have more personalized content and are not accessible to you or anyone else without your written permission or a court order.

I may examine my clinical record if I request it in writing. However, there are circumstances when Valliere & Counseling Associates, Inc. might not permit me to do this or might have to take out some of the information in my file, like those that involve danger to me and others, where information has been supplied by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and the clinician believes that access is reasonably likely to cause substantial harm to such other person. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I might be required review the records with my clinician or have them forwarded to another mental health professional who can discuss the contents with me. If my request for access to records is refused, I have a right of review (except for information supplied to the agency confidentially by others), which I will discuss with my clinician.

I can request that my record is amended and provide restrictions regarding what information is disclosed to others. Also, I can request to know what information has been disclosed to others and where it was sent. I can have a copy of any complaints I have about how my information is handled and about the policies of Valliere & Counseling Associates, Inc. in my record. I have a right to a copy of this agreement, the HIPAA notice form, and to view the agency's policies and procedures regarding privacy.

### *Minors and Parents*

Confidentiality in treatment is critical to the process. I understand that if I am under 18, the law might allow my parents to examine my file. However, I must give consent for information to be shared if I am over 14. My parents have the right to know my attendance, especially if they are responsible for payment. Unless I am a danger to myself or others or meet any of the other exceptions, my therapist will only share general information with my parents. In cases where my therapist is concerned with my behavior or well-being, the therapist will encourage me to tell my parents and will facilitate a discussion between us. I will be informed what my therapist plans to or has told my parents and will strive to protect my record and represent me accurately.



**Confidential***Social Media*

Social media poses a serious risk to my privacy and confidentiality. Given that, I understand that Valliere & Counseling Associates, Inc./Forensic Treatment Services has adopted a social media policy in order to be protect me and my confidentiality. The guidelines are as follows:

1. If I request to be contacted by email in any way, I will sign a consent, provide an email address, and specify the type of information to be communicated. If I email the clinician without this documentation, I am granting permission for email communication until such a consent can be signed. Email communications might become part of my record.
2. I understand that it is a policy of Valliere & Counseling Associates, Inc./Forensic Treatment Services to not use texting or messaging in any form with clients. I should not have any phone number from a therapist that is personal and should not receive text messages or instant messages in any form. I will report this if I do as it is a form of communication that is not secure or protected.
3. No clinician is permitted to "friend" me or connect with me on any social media. It is a potential violation of my confidentiality and privacy. I understand that "liking" a Facebook page, putting a review of services on-line using my name, geotagging the office, or otherwise identifying myself in association with the agency or clinician runs the risk of identifying myself as a patient/client. Valliere & Counseling Associates, Inc. cannot protect my privacy on the Internet.

*If you feel that your rights to confidentiality and/or privacy have been violated, please inform us immediately. You may also submit a written complaint to the U.S. Department of Health and Human Services (we will provide the address) or the Pennsylvania State Board of Psychology and/or Licensed Professional Counselors, without any fear of retaliation.*

My signature represents my understanding and consent to these conditions during the course of my treatment:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Client \_\_\_\_\_ accepted \_\_\_\_\_ rejected a copy of this form. (initial appropriate space)

**Confidential****NO SHOW POLICY**

Our agency is committed to your treatment; however, this is impossible without consistent follow-up visits with your therapist. No shows and late cancellations are costly to our practice and limit access to care for other patients. Your appointment time has been reserved for you. Please have the courtesy to attend your appointment.

1. It is your responsibility to cancel your appointment more than 24 hours prior to that appointment. Failure to cancel that appointment at least 24 hours in advance may result in a charge for a missed appointment.
2. If you fail to cancel your appointment, you will have a one-time courtesy and will not be charged a no-show fee.
3. If you have a repeated no show/late cancel you will be charged a \$25 no show fee and will be taken off your therapist's schedule. It is your responsibility to call to reschedule.

**NOTE:** *Emergencies arise from time to time and a late cancellation cannot be avoided. We will review emergency situations on a case-by-case basis.*

I agree to pay missed appointment/cancellation fees. I understand and agree to the conditions of payment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPOINTMENT REMINDERS**

As a courtesy, we can provide text reminders for your scheduled appointment. If you wish to receive these reminders, please initial below. These reminders will simply say that you have a treatment appointment.

\_\_\_\_\_ I consent to receive appointment reminders from Valliere & Counseling/Forensic Treatment Services via text to my mobile phone.

\_\_\_\_\_ I do not want to receive appointment reminders.

Patient Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\* It is your responsibility to inform us about changes to the phone number you are receiving text reminders on. You may revoke your consent to receive text reminders in writing. Thank you.



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**Possible Risks**

Despite the best efforts of your therapist to ensure HIPAA compliant encrypted communication, tele-therapy poses some risks to the use of technology, including, but not limited to:

- A disruption in the session due to technical or electrical failure;
- Interception of the transmission by unauthorized persons;
- Access to your electronic information by unauthorized persons;
- Interruption of the session or violation of confidentiality due to an unprotected environment of the client;
- Limited experience of the relationship due to the absence of face-to-face service; and
- Unexpected interruptions due to a less controlled client environment.

**I have read, understand, and agree to the conditions and information provided above regarding teletherapy:**

**Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

