Mynd Works COUNSELING SERVICES

jfs
A PROGRAM OF JEWISH FAMILY SERVICE OF GREATER HARRISBURG, INC.

# ADULT INTAKE

**Name** _____ **Date** _____

**Address** _____ **City** _____ **State** _____ **Zip**_____

**Phone** *(home)*_____ *(work)* _____ *(cell)* _____

**Birthdate** _____ **Gender** _____

**Who referred you to JFS?** _____

**Preferred method of contact (choose one and provide contact information):**

Email _____ Text (carrier: _____) Phone _____

**Describe the reason you are coming for counseling** _____

_____

**What would you like therapy to do for you?** _____

_____

**Please list all persons who live with you:**

| *Name* | *Relationship* | *Age* | *Gender* | *Employer/Occupation* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**How do you get along with the people you live with currently?**_____

_____

**Describe your family relationships when you were growing up. Any problems/concerns with family members?**_____

_____

**Employment** _____ **Employer** _____

**Describe any issues you've had with employment**_____

_____

**Education/highest grade completed** _____

**What was school or college like for you? Were you involved in any extracurricular activities like music, sports, clubs?**_____

_____

**Is religion or spirituality important to you?**_____

_____

**Any cultural information you wish to share** _____

_____

**Any sexual identity information you wish to share**_____

_____

**Have you experienced any trauma as a child or as an adult (abuse-physical, emotional, or sexual; domestic violence; prolonged separations from parents or caregivers)? If yes, please briefly describe:**_____

_____

_____

**Have you had any involvement in the legal system (charges pending, criminal behaviors)? Are you experiencing any legal issues at present? If yes, please explain:** _____

_____

_____

**What are the top 3 stressors in your life right now?** _____

_____

_____

**Any substance use or abuse in the past or currently?**_____

_____

_____

**Please check all that apply, and describe briefly if checked:**

- ☐ *current medical conditions* _____
- ☐ *significant medical problems in the past* _____
- ☐ *allergies* _____
- ☐ *sleep problems* _____
- ☐ *problems with eating habits* _____

☐ *problems with personal hygiene* _____

☐ *other health concerns* _____

**Have you ever been involved with any of the following services?**

| Previous | Current | | Approximate Date/Name of Provider/Agency |
|---|---|---|---|
| ☐ | ☐ | *Counseling or Therapy* | _____ |
| ☐ | ☐ | *Psychological evaluation* | _____ |
| ☐ | ☐ | *Psychiatric evaluation* | _____ |
| ☐ | ☐ | *Psychiatric Med. Management* | _____ |
| ☐ | ☐ | *Children & Youth/CPS* | _____ |
| ☐ | ☐ | *Other (describe):* | _____ |

**Have you had any previous mental health diagnosis? If so, please list:** _____

_____

_____

**Who gave the diagnosis and when**? _____

**Are you prescribed any medication(s)?** ☐ *yes* ☐ *no* If yes, please provide the following:

| *Name* | *Dosage* | *Frequency* | *Reason For Taking* | *Date Started* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

_____ _____

**Client Signature** **Date**

_____ _____

**Therapist Signature** **Date**

**Name of Client** _____ **Date of Birth** _____ **Age** _____

## CLIENT RIGHTS AND RESPONSIBILITIES

Welcome to Jewish Family Service of Greater Harrisburg, Inc. Our goal is to make your experience at JFS as productive and beneficial as possible. As a client of JFS, you have rights and responsibilities as you participate in our programs and/or receive services.

**Statement of Client's Rights:**

1. JFS serves anyone in need within its service area, and will not discriminate on the basis of race, ethnicity, color, gender, sexual orientation, disability, age, country of origin or religion. You have the right to be treated with courtesy and respect.
2. You have the right to fair and equable treatment without discrimination on the basis of race, ethnicity, color, gender, sexual orientation, disabilities, age, country of origin or religion.
3. You have the right to receive information communicated in a manner appropriate to your age, cognitive, and/or linguistic ability.
4. You have the right to receive services appropriate for your needs.
5. You have the right to be referred to another program or service if your needs exceed the services available through JFS.
6. You have the right to participate in the treatment planning process and decisions regarding services.
7. II you are over the age of 14, you have the right to consent or refuse treatment or involvement in our programs or services, unless such authority has legally been given to someone else. Should you choose to refuse services, JFS staff will advise you of the potential consequences or effects of discontinuing services. JFS reserves the right to determine guardianship status for minor children and dependent adults.
8. You have the right to privacy. Your relationship and communication with JFS staff and any personal information and/or records are kept confidential. JFS will only release information with appropriate written authorization, except as required by law or professional ethics. Confidentiality will not be maintained in the case of suspected child abuse or neglect or if the client poses a threat to themselves and/or others.
9. You have the right to express concerns or complaints about the services provided through JFS in accordance with the Grievance Policy without fear of recrimination, and for such concerns or complaints to be addressed and, whenever possible, satisfactorily resolved.

**Statement of Client Responsibilities:**

1. You are responsible for participating in the treatment service or program.
2. You are responsible for behaving appropriately within the treatment service area.
3. You are responsible for attending all scheduled appointments. Your appointment time is reserved exclusively for you. If you must cancel an appointment, do so at least 24 hours in advance or you may be charged a fee for the appointment.
4. You are responsible for payment of any fee-based services at the time of your appointment. It is your responsibility to contact your insurance regarding coverage information and fee reimbursement. JFS will provide you with any invoices or receipts for your insurance company, should you have coverage that may reimburse you. You may apply to have your fee adjusted based upon a sliding scale. You will be expected to pay your fee at the time of your appointment even if you the sliding scale fee.
5. JFS makes every effort to inform clients of the basic expectations it has for individuals using its services and any activity which could result in discontinuation of service. JFS reserves the right to terminate services if a client becomes abusive, violent, or in any way threatens a staff member; or if JFS believes continuation may create risk to the client, staff or other clients. JFS may also refuse to serve a client who does not wish to participate in the treatment planning or comply with a specific program requirement; if client is an active substance abuser; or if the client misses three appointments in a row without 24 hour notice or reasonable explanation. If JFS terminates service, the client will be given the names of three referral sources.

**I understand these rights and responsibilities.**

| | | |
|---|---|---|
| **Signature of Client or Responsible Party** | **Date** | **Relationship to Client** |

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## AUTHORIZATION FOR TREATMENT
## ADULT (AGE 18 AND OVER) or MINOR AGE 14-17

**Name of Client** _____ **Date of Birth** _____ **Age** _____

I consent to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc. I understand that participation in this program is voluntarily and I may revoke this consent at any time.

_____ _____

**Signature of Client - Adult (Age 18 and Over) or Minor Age 14-17** **Date**

## FINANCIAL RESPONSIBILITY

- Fees for outpatient mental health services at Jewish Family Service of Greater Harrisburg, Inc., are:

| | |
|---|---|
| Intake/Diagnostic Session | $125.00 |
| Individual therapy session - 30 minutes | $ 45.00 |
| Individual therapy session - 45-60 minutes | $110.00 |
| Family or Couples Session | $110.00 per hour |
| Group Therapy Session | $ 45.00 per hour |
| Preparation for Court | $100.00 per hour |
| Appearing in Court | $250.00 per hour |
| Form Completion | $25.00 |

- I assign directly to Jewish Family Service of Greater Harrisburg, Inc., all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize Jewish Family Service of Greater Harrisburg, Inc.to release all information necessary to secure the payment of benefits.
- I authorize the use of this signature (as “Signature on File”) on all insurance submissions.
- Missed appointments or late cancellations represent a cost to us, and time to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Depending on my insurance plan’s policies, I understand that I may be charged a $25.00 fee for missed or late-canceled appointments.

**Signature of Client or Responsible Party** **Date** **Relationship to Client**

## AUTHORIZATION TO CONFIRM OR CORRESPOND

I hereby authorize Jewish Family Service of Greater Harrisburg, Inc., to contact me at my home or work to confirm my appointments (or my child's appointments), and to send periodic correspondence to my home. I am responsible for providing the method of contact I prefer.

**Signature of Client or Responsible Party** **Date** **Relationship to Client**

## NOTICE OF PRIVACY PRACTICES

I have received a copy of the legal duties and privacy practices of Jewish Family Service of Greater Harrisburg, Inc., in regard to protected health information.

**Signature of Client or Responsible Party** **Date** **Relationship to Client**

## EMERGENCY SERVICES

After office hours, if your call is of an emergent nature, please go to the closest emergency room to be seen by Crisis Intervention Services or call Crisis Intervention at one of the following numbers:

**Cumberland County: 717-243-6005 or 717763-2222**
**Dauphin County: 717-232-7511**
**Franklin County: 717-264-2555**
**Perry County: 717-834-3326**