



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 _____ 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:

| <i>Name</i> | <i>Relationship</i> | <i>Age</i> | <i>Gender</i> | <i>Employer/Occupation</i> |
|-------------|---------------------|------------|---------------|----------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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 |
|--------------------------|--------------------------|------------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Counseling or Therapy</i> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Psychological evaluation</i> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Psychiatric evaluation</i> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Psychiatric Med. Management</i> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Children & Youth/CPS</i> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Other (describe):</i> | _____ |

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:

| <i>Name</i> | <i>Dosage</i> | <i>Frequency</i> | <i>Reason For Taking</i> | <i>Date Started</i> |
|-------------|---------------|------------------|--------------------------|---------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Client Signature

Date

Therapist Signature

Date

CLIENT NAME _____

ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often...Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?

If yes enter 1 _____

2. Did a parent or other adult in the household often or very often...Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

If yes enter 1 _____

3. Did an adult person at least 5 years older than you ever...Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

If yes enter 1 _____

4. Did you often or very often feel that ...No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

If yes enter 1 _____

5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

If yes enter 1 _____

6. Were your parents ever separated or divorced?

If yes enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?

If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

If yes enter 1 _____

10. Did a household member go to prison?

If yes enter 1 _____

Now add up your "Yes" answers: _____ this is your ACE Score.

CLIENT NAME _____

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 equitable 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. If 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.



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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**

CLIENT NAME _____

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 | \$140.00 |
| Individual therapy session - 30 minutes | \$ 45.00 |
| Individual therapy session - 45-60 minutes | \$125.00 |
| Family or Couples Session | \$125.00 per hour |
| Group Therapy Session | \$ 45.00 per hour |
| Group DBT Session | \$100.00 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.



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Signature of Client or Responsible Party Date Relationship to Client

CLIENT NAME _____

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 read the notice of privacy practices of Jewish Family Service of Greater Harrisburg, Inc., in regard to protected health information. A copy is available upon request.

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 717-763-2222**
- Dauphin County: 717-232-7511**
- Franklin County: 717-264-2555**
- Perry County: 717-834-3326**