# ADOLESCENT INTAKE

Teens 14-17

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender _____

Describe the reason you are bringing your child for counseling

_____

Who referred you to JFS/Mynd Works?

_____

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

☐ Email ☐ Text ☐ Phone

_____ _____ _____

## Family Information

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Insurance Company _____

Member ID _____

Phone number on the back _____

Policy holder _____ Policy Holder Date of Birth _____

Please list ALL persons living with the child (including parents/guardians):

| Name | Relationship to Child | Date of Birth | Gender | Marital Status | Employer/Occupation |
|---|---|---|---|---|---|
| | | | | | |
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Please list family members NOT living with the child (Parent, Siblings, Stepparents, Birth Parents, etc.):

| Name | Relationship to Child | Date of Birth | Gender | Marital Status | Employer/Occupation |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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Family's religious, spiritual, cultural, or sexual identity information you wish to share

Is the child now or has the child been in any of the following?

☐ Foster Care ☐ Custody of Relative ☐ Adopted

If yes, please briefly describe the situation

## Social

How does the child get along with peers/friends?

How does the child get along with parents/caregivers or other adults?

How does the child get along with sibling(s)?

Does the child have hobbies or participate in activities (sports, school clubs, scouts, etc.)?

## Educational

Current Grade

School/School District

What other schools has the child attended?

Does the child have an Individualized Education Plan (IEP)? ☐ YES ☐ NO

If yes, what type?

- ☐ Autism
- ☐ Deaf/Blindness
- ☐ Deafness
- ☐ Emotional disturbance
- ☐ Hearing impairment
- ☐ Intellectual disability
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Other health impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Traumatic brain injury
- ☐ Visual impairment

Does the child have academic, attendance, or behavioral issues? ☐ YES ☐ NO

If yes, please describe:

## Developmental History

Was the baby carried to term? ☐ YES ☐ NO

Birth Weight:

Did mother or child experience medical complications during pregnancy, delivery, or following delivery?
☐ YES ☐ NO

If yes, please briefly describe

Did the child meet developmental milestones (walking, talking, toilet-training, school readiness skills, etc.) at expected ages? ☐ YES ☐ NO

If no, please briefly describe

## Physical and Mental Health History

Has the child been prescribed any medication(s)? ☐ YES ☐ NO

If yes, please provide the following:

| Name | Dosage | Frequency | Reason For Taking | Who prescribed it? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Does the child have any allergies? ☐ YES ☐ NO

If yes, please describe:

Please check all that apply to the child, and describe briefly if checked:

- ☐ current medical conditions
- ☐ medical problems in the past
- ☐ sleep problems
- ☐ problems with eating habits
- ☐ problems with personal hygiene
- ☐ other health concerns

Does the child have any previous mental health diagnosis? ☐ YES ☐ NO
If yes, please list:

If yes, who gave the diagnosis and when?

Has the child ever been involved with any of the following services?

| Previous | Current | | Approx. Date/Name of Provider/Agency |
|---|---|---|---|
| ☐ | ☐ | Outpatient Counseling/Therapy | |
| ☐ | ☐ | Psychological evaluation | |
| ☐ | ☐ | Psychiatric evaluation | |
| ☐ | ☐ | Psychiatric Med. Management | |
| ☐ | ☐ | BHRS Services (BSC, MT, TSS) | |
| ☐ | ☐ | Family-Based Mental Health | |
| ☐ | ☐ | Speech/Language Therapy | |
| ☐ | ☐ | Occupational Therapy | |
| ☐ | ☐ | Children & Youth/CPS | |
| ☐ | ☐ | Other (describe): | |

.Has the child experienced any of the following (if yes, please briefly describe the situation)?

- ☐ abuse-physical, emotional, or sexual
- ☐ witnessing domestic violence
- ☐ prolonged separations from parents or caregivers)
- ☐ other trauma

Please indicate if any person in the child's birth or adoptive family has experienced the following:

| | Name/Relationship to the child: |
|---|---|
| ☐ ADHD | |
| ☐ Anxiety Disorder | |
| ☐ Bipolar Disorder | |
| ☐ Chronic Physical Illness | |
| ☐ Depression | |
| ☐ Drug and/or Alcohol Abuse | |
| ☐ Learning Problems | |
| ☐ Other Physical or Mental Illness | |
| ☐ Schizophrenia | |

Please describe the child's overall strengths and areas of concern:

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

Signature of Person Completing Form | Relationship to Child | Date

## 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 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:**
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.

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.

You have the right to receive information communicated in a manner appropriate to your age, cognitive, and/or linguistic ability.

You have the right to receive services appropriate for your needs.

You have the right to be referred to another program or service if your needs exceed the services available through JFS.

You have the right to participate in the treatment planning process and decisions regarding services.
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.

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.

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:**

You are responsible for participating in the treatment service or program.

You are responsible for behaving appropriately within the treatment service area.

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.

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 have sliding scale fee.

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.

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

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

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

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

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.

☐ *By checking this box and typing my name, I am verifying that this is my electronic signature.*

**Signature of Client - Adult (Age 18 and Over)** **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 covered or not covered 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.

*Revised 06/26/2019*

☐ *By checking this box and typing my name, I am verifying that this is my electronic signature.*

**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.

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

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.

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

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

3333 North Front Street, Harrisburg, PA 17110 717.233.1681 717.234.8258 www.jfsofhbg.org

# Mynd Works *No Show/Late/Cancellation Policy*

**Please read and sign the following No Show/Late/Cancellation policy**

Please notify your therapist as soon as you know you are unable attend your scheduled session or are running late. This can be done by emailing your therapist directly when possible or calling the front office at JFS. The notice will allow us to offer your spot to another client in need. Please see the following policy for details and talk with your therapist if you have questions.

**Any fees accrued will need to be paid before your next scheduled session.**

1. **No Show and Late Cancellation** (less than 48hrs. before your scheduled session)
   If you do not show up for a scheduled appointment or make a late cancellation, there will be a **$25 fee (Not applicable to Medicaid only clients)**. If we can schedule you for a different time that same week (dependent solely on your therapists availability) we will waive the fee. If there are **3 unexcused or 2 consecutive unexcused no shows/late cancellations for appointments within a 6 month period**, you will be removed from your therapist's schedule and returned to our waiting list to allow other clients access to services.
2. **Late arrival to appointment** (more than 10 minutes past the scheduled time)
   If you arrive 10 minutes or more after your scheduled appointment time, your therapist may cancel the session which will be considered a Late Cancellation resulting in a **$25 fee (Not applicable to Medicaid only clients)**. If we can schedule you for a different time that same week (dependent solely on your therapist's availability) we will waive the fee. If there are **3 unexcused or 2 consecutive unexcused late arrivals for appointments within a 6 months period**, you will be removed from your therapist's schedule and returned to our waiting list to allow other clients access to services.

Again, the purpose of our policy is to make sure we are establishing strong mutually respectful therapuetic relationships with our clients and to allow our therapists to serve as many clients in need as possible. Please talk with your therapist if you have any additional questions or concerns and thank you for allowing us to serve you. Please sign below to indicate that you have read and understand our No Show/Late/Cancellation policy.

☐ ***By checking this box and typing my name below I confirm this is my digital signature***

Client Signature _____ Date _____

3333 North Front Street, Harrisburg, PA 17110 717.233.1681 717.234.8258 www.jfsofhbg.org

The staff of Mynd Works is deeply committed to providing you with professional and compassionate quality mental health services. Your therapy appointment should be viewed as any other important medical appointment and attended on time as scheduled. Missing or arriving late to your session can not only make it impossible to give your time slot to another client in need, but it can also negatively impact your therapeutic journey. Mynd Works is unable to bill insurance for a scheduled appointment that is missed or cancelled.

We understand that there are exceptions that make it impossible to attend your scheduled appointment. Excused absences are as follows: you are too ill to attend your appointment or are contagious with any medical condition or environmental hazzard (lice, bedbugs, scabies etc); or you are having an issue with transportation such as last minute car problems or a traffic obstruction. During the COVID 19 crisis, some other exceptions may apply and you can get further clarification from your therapist. Both the therapist and the client have the right to discontinue the relationship at any time.

Again, our staff is here to support you through your healing journey and our policies exist to protect and support all parties involved. We commit to you that we will give you 48 hours notice if we need to cancel or change your scheduled appointment and that we will be available for your appointment no later than 10 minutes after your scheduled time.

Here are some tips that other clients have found helpful in managing appointments:

- Use the calendar on your phone to enter your appointments at the end of each session
- Have a planner or calendar available to record your appointment at the end of each session
- Use an alarm on your device or clock to remind you when it's time to log on to or leave for your session
- Have other important appoinments and work schedules available when you schedule with your therapist to avoid any time conflicts
- If you forget when your scheduled session is, please don't hesistant to email your therapist or call the front office.
- While we are operating remotely, email your therapist if you are having trouble connecting to the app.

☐ ***By checking this box and typing my name below I confirm this is my digital signature***

Client Signature_____ Date_____

# Credit Card Authorization Form

**Please complete all fields.**
**You may cancel this authorization at any time by contacting us.**
**This authorization will remain in effect until cancelled.**

| **Credit Card Information** | | | |
|---|---|---|---|
| Card Type: ☐ MasterCard | ☐ VISA | ☐ Discover | ☐ AMEX |
| ☐ Other | | | |
| Cardholder Name (as shown on card): | | | |
| Card Number: | | | |
| Expiration Date (mm/yy): | | Security Code: | |
| Cardholder ZIP Code (from credit card billing address): _____ | | | |

I,_____, authorize_____to charge my credit card above for copays. I understand that my information will be saved to file for future transactions on my account via Telehealth. I understand that this transaction will be completed without me present. I give Jewish Family Service/Mynd Works Counseling permission to process my card for this intended purpose.

☐ *By checking this box and typing my name, I am verifying that this is my electronic signature.*

_____ _____

Customer Signature Date

**Jewish Family Service of Greater Harrisburg, Inc.**

**NOTICE OF PRIVACY PRACTICE**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This notice will tell you how we handle information about you. It tells how we use this information in the office, how we share it with other professionals and organizations, and how you can see it. We are required to tell you about this because of the privacy regulation of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). Your contract for services provides a signed statement acknowledging this notice.

**Uses and Disclosures**

There are situations where JFS may use or disclose to another person or entities your confidential information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information (PHI) for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your records to accomplish the intended purpose of the disclosure.

Treatment: We will use your information to make decisions about the provision, coordination or management of your care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another care provider whom we need to consult with respect to your care. We may also disclose certain information to a facility or other providers should you require hospital care. These are only examples of uses and disclosures of information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and preauthorization of services or review of services for purposes of reimbursement. This information may also be used for billings, claims management and collection purposes together with related health care data processing through our system.

**Use and Disclosure Without Acknowledgement or Authorization**

There are certain circumstances under which we may not use or disclose your information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. We are required to disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We are also required to report instance of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement official's information that you or another person are in immediate threat of danger to your health or safety as a result of a violent activity. We must also provide medical record information when ordered by a court of law to do so.

**Authorization for Use or Disclosure**

Except as outlined in the above sections, your information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases with may be contained in your records. We likewise will not disclose your information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to education authorities without your written authorization.

**Access to PHI by Parents, Guardians, or Other Legally Authorized Personal Representatives**

Commonwealth of Pennsylvania law permits or requires disclosure of protected health information under most circumstances to parents of minor children, guardians of children or adults, and to other persons acting in a similar legal capacity on behalf of an individual. We will act consistently with state law with respect to treatment and disclosure.

**Additional Uses and Disclosures**

We may contact you from time to time to provide appointment reminders or information about your care and/or other benefits or services that may be of interest to you.

**Individual Rights**

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction
2. You have the right to request receipt of confidential communications of your information by an alternative means or at an alternative location.
3. You have the right to inspect copy and request amendment to your records. Access to your records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law.
4. All request for inspection, copying and/or amending information in your records must be made in writing and be address to “Privacy Officer” at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to other permissible use or disclosure, and otherwise as allowed by law.
6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to “Privacy Officer” at the address noted below.

**Our Duties**

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

**Complaints**

You may file a written complain to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your records has been violated. All complaints must be in writing and must be address to the Privacy officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints online at the government's website: http://www.hhs.gov/ocr/hipaa

**Contact Person**

All questions concerning this Notice or requests made pursuant to it should be addressed to:

**Business Office Manager**
**Jewish Family Service of Greater Harrisburg, Inc.**
**3333 N. Front Street, Harrisburg, PA 17110**
**Or call 717-233-1681**

**Effective Date**

This notice is effective **December 15, 2017** and applies to all protected health information contained in your records maintained by us.