Staff Printed Name: _____
Staff Initials: _____

Behavioral Services Center
Domestic Violence Services

8707 Skokie Boulevard - Suite #207, Skokie, IL, 60077
Phone: (847) 673 - 8577 | Fax: (847) 568 - 0411

Behavioral Services Center: Patient Demographic Form

Personal Information

Last Name:_____First Name:_____Middle Initial: _____

Is this your legal name? Please indicate: ☐ Yes ☐ No

If not, please provide your legal name: _____

Former name: _____

Please select the applicable option: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Age: _____

Indicate current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Social Security Number: _____

Birth Date: _____/_____/_____ Gender: ☐ M ☐ F ☐ Non-Binary

Parent/Guardian/ or Significant Other Info: First/Last Name: _____

Relationship to Client: ☐ Parent ☐ Guardian ☐ Significant Other (Specify): _____

Race/Ethnic Origin: _____ Religion: _____

First Language: _____ Second Language: _____

Interpreter Services: ☐ None Required ☐ American Sign Language ☐TDD/TYY

☐ Spoken Language ☐ Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

P.O Box: _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

Email Address: _____

Referred By: _____ Preferred Method of Communication: _____

Behavioral Services Center:
Authorization to Disclose/Obtain Information

I _____ (print name) authorize Behavioral Services Center to disclose and obtain the following information:

- Evaluations
- Assessments
- Treatment Plans
- Progress Notes
- Discharge Summaries
- Billing Financial Records
- Other (Specify Here): _____

For the purposes of:

- Personal Use
- Continuity of Care
- Referral/Transfer
- Billing
- Case Management
- Other (Specify Here): _____

Information may be disclosed/obtained via mail, in-person, phone, email, or fax.

Disclose to: First/Last Name: _____

Address: _____ City/State/Zip: _____

Phone/Fax/Email: _____

Obtain From: First/Last Name: _____

Address: _____ City/State/Zip: _____

Phone/Fax/Email: _____

This Authorization is valid until: _____/_____/_____

It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as mental health and substance abuse. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations. I understand that I may revoke this authorization; however, the revocation must be in writing to the Behavioral Services Center. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communication until it is received by the Behavioral Services Center. Refusal to sign this form will result in no information to be disclosed or obtained. Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment.

Signature Date

US Citizen: □ Yes □ No □ Other: _____

Military Status: □ Veteran □ Active □ Reserve □ None

Driver's License Number: _____ Medicaid # (if applicable): _____

Employee Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Other:_____

Occupation: _____ Annual Household Income: _____

Living Arrangement: □ Lives Alone □ Family Household □ Independent Living
□ State Operated Facility □ Foster Care □ Homeless
□ Lives with parent(s), or guardian(s) □ Jail or Correctional Facility
□ Residential/INstitutional Setting □ Community Integrated Living
□ Other: _____

Highest Education: □ Never attended □ Pre-K/Kindergarten □ Grade 1-3
□ Grade 4-5 □ Grade 6-8 □ Grade 9-12 □ H.S Diploma/GED
□ Some College □ Associate's Degree □ Bachelor's Degree
□ Trade/Technical Training □ Professional Certificate
□ Master's/Doctoral Degree

Established Supports _____

Physician: Agency: _____Contact Name: _____
Phone: _____ Email: _____

School/Daycare: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Counselor/Therapist: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Child Welfare Worker: Agency: _____Contact Name: _____
Phone: _____ Email: _____

ISC/PAS Agent: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Probation Officer: Agency: _____Contact Name: _____
Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Other:_____: Agency: _____Contact Name: _____

Phone: _____ Email: _____

Insurance Information

Please indicate primary insurance: _____

Group #: _____ Policy #: _____

Co-Payment: _____ Birth Date: _____/_____/_____

Subscriber's Name: _____ Subscriber's S.S #: _____

Patient's relationship to the subscriber:_____

Name of Secondary insurance (if applicable): _____

Subscriber's Name: _____ Subscriber's S.S #: _____

Birth Date: _____/_____/_____ Group #: _____

Policy #: _____ Co-Payment: _____

Person responsible for bill: _____ Birth Date: _____/_____/_____

Address (if different): _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

In Case of Emergency

Name of local friend or relative (not living at same address): _____

Relationship to patient: _____

Phone Number: (____)_____-_____ Cell Number: (____)_____-_____

Other Contact Information: _____

I **authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance and believe that the above information is true to the best of my knowledge.**

Signature Date

Behavioral Services Center: Client's Rights

The Behavioral Services Center (BSC) is determined to provide the best and the most appropriate care to its clients. The BSC is obliged to protect its clients' rights and treat every Client with respect. The BSC guarantees to adhere to the following policies:

- BSC does not discriminate against its clients on the basis of race, religion, ethnicity, disability, sexual orientation, or HIV status.
- BSC will not deny mental health or substance abuse services because of age, sex, race, sexual orientation, HIV status, religious belief, ethnic origin, marital status, physical or mental disability or criminal record unrelated to present dangerousness.
- The client has a right to be free from abuse, neglect, retaliation, humiliation and financial and other exploitation.
- The client has a right to confidentiality and privacy within the limits of the law (The Illinois MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT).
- The client has a right to be provided services in the least restrictive setting.
- The client has a right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
- The client has the right to contact the Illinois Guardianship and Advocacy Commission and Equip for Equality, Inc. BSC will offer assistance to a client in contacting these groups, giving each client the address and telephone number of the Illinois Guardianship and Advocacy Commission and Equip for Equality.
- The client has the right to contact HFS or its designee of the clients healthcare benefit and the process for reviewing grievances.

BSC ensures that none of its facilities used for the face-to-face interviews are locked and its clients are never placed in seclusion or in an environment from which they cannot voluntarily exit.

BSC understands and guarantees that all information that it receives about its clients is strictly confidential in accordance with the Illinois MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT. In particular, if the BSC finds out information about the Client's HIV/AIDS status, it will keep this information strictly confidential. The BSC will keep the results of the Client's anonymous drug or HIV testing strictly confidential. BSC will keep mental health and substance abuse information confidential. BSC guarantees that *all* clients regardless of their disability have access to its services in the facility. BSC will provide special accommodations to clients with disability on an individual

basis as required by the American with Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS5].

Every client has the right to sign or withhold consent to release information about services received on The Release of Information Consent Form. Clients may authorize BSC to share treatment information by signing a consent form. BSC will provide access or referral to legal entities for appropriate representation, self-help support services and advocacy support services.

If a client disagrees with BSC's policies and procedures, they can appeal in writing to the management and the board of directors. BSC will provide a written response within 10 business days to the submitted appeal. Every appeal will be considered on a case-by-case basis. Clients cannot file an appeal regarding the same policy of the BSC more than three times. The client has the right to request communication about their own health information by alternative means or to alternative locations. Clients must make this request in writing. The request must specify the alternative means or location, and provide satisfactory explanation in regards to payments handled under the alternative means or location you request. The client has the right to refuse treatment and refuse treatment recommendations including medication but BSC may refuse to continue providing services and provide referrals to other service providers. BSC will provide information to the client in sufficient time to facilitate decision making. If the client is potentially harmful to self or someone else or is unable to take care of self, this section may not apply and we will assist in stabilizing the client before referring elsewhere.
Clients have the right to review or receive copies of his/her health information. The Client must make a request in writing to obtain access to their health information. If the client requests copies, the BSC will charge a reasonable cost-based fee. The client has the right to be involved in their own treatment plan and to know the risks and benefits of treatment and other options. Informed consent or refusal for assessment and treatment will be obtained in writing by BSC. The client also has a right to informed consent or refusal related to the service delivery, concurrent services, composition of the service delivery team, and involvement in research projects as applicable.

The client has the right to receive a list of instances in which BSC or BSC's business associates disclosed the client's information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years. If Client requests this information more than once during any 6 month period he/she will be charged a cost-based fee. The client has the right to request that BSC place additional restrictions on the use or disclosure of his/her health information. The BSC is not required to agree to these additional restrictions but if the BSC does, it will abide by our agreement (except in an emergency). The client has the right to request that BSC amends his/her health information. Client's request must be in writing and

explain why the information should be amended. The BSC may deny a Client's request under certain circumstances.

If a client is 12 years or older, they have the right to read and/or copy the records. Clients must request this in writing. There is a fee for photocopying. If Client is under the age of 18, the BSC must provide someone to help explain Client's records. Clients may refuse this help. Client's parent(s) or guardian(s) also have the right to read and copy of the Client's record; however, Client may decline to allow them to review your record. If Client gives other people permission to read or copy your record, it must be in writing. If the client is 12-18 years old, the client and therapist may object to information being given to Client's parent or guardian. All clients' records are kept strictly confidential. All clients' records are kept in a secure environment, secure file lock, and can be accessed only by authorized BSC personnel. All clients of the BSC have the right to refuse the services. In this circumstance, BSC staff must inform the client of the consequences resulting from such refusal and make sure that the client understands them.

This Notice of Privacy Practices explains how the Behavioral Services Center (BSC), its clinical staff may use and provide your Protected Health Information (called PHI) to others for treatment, payment, and health care "operations" as described below, and for other purposes allowed or required by law.

1. OUR RESPONSIBILITIES: The BSC takes the privacy of your and your child's health information seriously. We are required by law to keep your health information private and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep.

2. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)? Protected Health Information (PHI) is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

3. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE? "Health care operations" includes activities such as discussions between clinical staff; evaluating and improving quality; making travel arrangements to and from the BSC; arranging temporary housing; reviewing the skills, competence, and performance of health care staff; training future health care staff; dealing with insurance companies; carrying out medical reviews and auditing; collecting and studying

information that could be used in legal cases; and managing business functions.

4. HOW IS MEDICAL INFORMATION USED? The BSC uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. For example, your insurance company may need us to give them procedure and diagnosis information to bill for patient treatment we provide. Other health care providers or health plans reviewing your records must follow the same privacy laws and rules that the BSC is required to follow. Patient records also greatly help our researchers find the best possible treatment for diseases and medical conditions. All BSC
researchers must follow the same rules and laws that other health care providers have to follow to keep patient information private. Details that may identify patients will not be disclosed for research purposes to anyone outside of the BSC without written permission from the patient or the patient's parent or legal guardian.

5. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

● Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, treatment plans, and research study requirements).

● We will use medical information to plan treatment.

● We may disclose Protected Health Information to another provider for treatment (such as, referring doctors, specialists, and providers at the Behavioral Services Center).

● We may send claims to your insurance company containing medical information. We might also contact their utilization review department to receive precertification (approval for treatment in advance).

● We may use the emergency contact information you gave us to contact you if the address we have on record is no longer correct.

● We may contact you to remind you of the patient's appointment by calling you or mailing a postcard.

● We may contact you to discuss other possible treatments or benefits related to health that might interest you.

● We may use information to schedule travel to and from Behavioral Services Center.

● The patient's name, home address, location in Behavioral Services Center housing, and arrival date may be given to ALSAC, a charitable organization with the sole purpose of raising funds for Behavioral Services Center. Before any more information is given to ALSAC, you will be asked to sign another consent document known as an Authorization Form

6. WHY DO I HAVE TO SIGN A CONSENT FORM? When you sign the Consent for Release of Information, you are giving the BSC permission to use and disclose (provide to others) Protected Health Information for treatment, payment, and health care operations, as described above. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records, and other privileged categories of information, all of which require a separate permission. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment, or health care operations or as required or permitted by law.

7. WHAT ARE PSYCHOTHERAPY NOTES? Psychotherapy notes are notes recorded (in any form) by a mental health professional for the purpose of studying a conversation that took place during a private counseling session. This session can be with a single person, a group, or a family. Conversation notes from a counseling session are separated from the rest of the patient's medical record. Psychotherapy notes do not include: notes about which medicines you are taking or how those medicines affect you; the start and stop times of counseling sessions; the types of treatment you are given; how often treatments are given; the results of clinical tests; and any summary of the following items: diagnosis, functional state, the treatment plan, symptoms, expected outcome, and progress to date.

8. WHAT IS PSYCHOSOCIAL INFORMATION? Psychosocial information is information given to your social worker about your family's social history and counseling services you have received.

9. WHY DO I HAVE TO SIGN A SEPARATE PERMISSION FORM? To provide patient Protected Health Information to other people for any reason other than treatment, payment, and health care operations (described above) or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly explains how they wish the information to be used and disclosed. The following are some examples of information that require separate permission before we can release it:

● Psychotherapy notes

● Information and photographs shared with ALSAC for its fundraising and public relations activities

● Information used in scientific and educational publications, presentations, and materials related to the work at BSC

● Information shared with other clinical and scientific cooperative groups that Behavioral Services Center works with in carrying out its mission to advance cures, and means of

prevention, for pediatric catastrophic diseases through research and treatment.

10. CAN I CHANGE MY MIND AND WITHDRAW PERMISSION FOR BSC TO DISCLOSE PHI? You may change your mind and withdraw (revoke) permission, but we cannot take back information that has been released up to that point. Permission cannot be withdrawn if (1) the information is needed to maintain the integrity of the research study, or (2) if the permission was originally given to obtain insurance coverage. All requests to withdraw permission for uses and disclosures of PHI should be made in writing. The request should be submitted to Patient Registration, which will then forward this information to the Privacy Officer and the Director of Health Information Management.

11. WHEN IS MY CONSENT *NOT* REQUIRED? The law requires that some information may be disclosed without your permission during the following times:

- In an emergency
- When communication or language is very limited
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To report Elder abuse
- To report information under the Firearm Owners Identification Act (FOID)
- To certain government agencies who monitor activity
- In connection with court or government cases
- For law enforcement purposes
- To coroners and funeral directors and for organ donation
- If health or safety is seriously threatened

12. GRIEVANCE PROCEDURE: You have the right to file a grievance for any concerns you have related to BSC including a violation of the above rights, concerns about treatment, or other concerns:

CLIENT GRIEVANCE POLICY & PROCEDURE:

It is the policy of Behavioral Services Center (BSC) to have a prompt and responsive way for you to submit a concern or complaint, free from intimidation or retaliation with the right not to be denied, suspended or terminated from services or have services reduced for exercising any

rights. If you have a concern or complaint about services provided by us, BSC will make reasonable efforts to come to a solution that is agreeable to all parties involved. Each client has the right to designate a representative or advocate to assist them with all of the stages of the grievance process and/or request the agency to assist them in filing a grievance if they so desire.

STEP ONE INFORMAL STAGE Talk first to your primary provider about the matter. Allow a reasonable response time for the two of you to talk out the situation. Present your viewpoint clearly. Be calm and reasonable in your presentation to your primary provider. It may help if you write it out. If you do not agree with the outcome or you feel your concern has not been addressed adequately, you may follow the procedures for STEP TWO below.

STEP TWO FORMAL STAGE If your grievance is not resolved, you may request a meeting with the Clinical Services Director, Dr. Eugene Isyanov, by filling out the attached Formal Grievance Form. Your primary provider or the front desk can provide a form for you and you can turn it in to any BSC employee. Then an appointment will be arranged with Dr. Isyanov.

Review the situation with the Dr. Isyanov. Include the solution you wish to see. You will be asked if you covered the information with your primary provider and turned in the Formal Client Grievance Form before you requested this appointment. If you did not, you will be referred back to the appropriate person, unless you can clearly identify why you should not talk to your primary provide about the matter. The Clinical Services Director, Dr. Isyanov, will make every attempt to resolve the matter. It is possible that Dr. Isyanov may take some time to weigh all viewpoints before making a decision, so don't expect an immediate response. You can expect a response within 2 weeks of meeting Dr. Isyanov, his decision is final. If your primary provider is Dr. Isyanov, another administrator will be assigned to meet with you.

13. RIGHT TO ADEQUATE AND HUMANE CARE: You will be assigned a therapist (e.g. social worker or psychiatrist) who will work with you on an individual Treatment Plan. You will be treated with dignity and respect. If you do not feel you are receiving adequate or humane care, you should report this to your therapist. You may also file a grievance as indicated in the grievance procedure above.

14. RIGHT TO BE FREE FROM ABUSE AND NEGLECT: It is your right to obtain treatment that is free from abuse and/or neglect.

15. RIGHT TO INFORMED CONSENT: You have the right to be involved in your treatment plan and to know the risks and benefits of treatment and other options.

16. RIGHT TO REFUSE TREATMENT: You have the right to refuse treatment, including

medication but we may not be able to continue to serve you. If you are potentially harmful to yourself or someone else, this section may not apply.

17. RIGHTS TO CONFIDENTIALITY: All information gathered while you are receiving services from us will be kept private unless:

1. You sign a written release indicating specific information to be released to another person or agency.

2. We receive a Court order to release information.

3. You have a Medical Emergency.

4. You might harm yourself or others.

5. You are unable to take care of yourself.

6. I consent to the use or disclosure of my protected health information by Clinicians for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Clinician.

7. Other exceptions as prescribed by law.

18. RIGHT TO ACCESS RECORDS: If you are 12 years or older, you have the right to read and or copy your records. You must request this in writing. There is a fee for photocopying. If you are under the age of 18, we must provide someone to help explain your records. You may refuse this help. Your parent(s) or guardian(s) also have the right to read and copy your record.

You have the right to ask that information in your file be changed, but we do not have to change the record. If we do not change the information, you may: 1. Put your own information in the file. Any time the information is released, your information will also be released. 2. Go to Court to attempt to have us change your information.

If we suspect a child with whom you are involved is abused or neglected, or we learn of child abuse or neglect we are mandated to report it to DCFS.

If you are 12-18, you and your therapist may object to information being given to your parent or guardian. Your parents or guardian in such a situation may petition the Court to review your

record.

We will only release specific information needed to meet the request or situation. These situations are:

1. When your therapist is mandated by the Federal, State Authorities to report if you have committed a crime on our property, or if threats are made against our organization, its staff or others.

2. If this clinic is audited by Federal, State or Local authorities, e.g. Public Health, Medicare, Public Aid, the Joint Commission of Accreditation Organization.

3. Your therapist may share information with his/her supervisor and co-workers when it is needed to help with treatment.

If your rights are restricted in any way by us, we must justify the restriction of any documentation in your file. You or your parent(s) or guardian or the above identified agencies will be notified of the restriction. You may not be denied, suspended, or terminated from service or have services reduced for exercising any of your rights. The rights included herein apply to you as well as all patients who receive services in our clinic. We request that you respect the rights and confidentiality of all patients who receive services. Your rights are protected in accordance with the Illinois Mental Health and Disabilities Code and the Illinois Mental

Health, HIPAA and Disabilities Confidentiality [Confidentiality Act [740 ILCS 110] and HIPAA (45 CFR 160 and 164)]. This is a summary of your rights. Please read them and/or have them read and explained to you. If you require additional help such as a translator, we can provide that service for you. After you read and understand your Rights, please sign this document indicating you have read and understand it and have been given a copy of the document.

I **, I agree and consent to that I have read and understood the Client's Rights and been provided a copy of this Client's Rights Document.**

Signature Date

Behavioral Services Center:

Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from medical devices and sound video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Medical Information & Records

All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, no telecommunications are recorded and stored.

Confidentiality

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Illinois law apply to information disclosed during this telemedicine consultation.

Rights

You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Risks, Consequences, & Benefits

You have been advised of all potential risks, consequences and benefits of telemedicine. Your health care practitioner has provided the information above and you have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions, if present, have been answered and you understand the written information provided above.

I **, I agree to participate in telemedicine consultations for procedure(s) provided by the Behavioral Services Center.**

Signature Date

Behavioral Services Center: Consent For Mental Health And Substance Abuse Evaluation And Treatment

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I, (print name) _____ hereby consent to receive Mental Health and/or receive Mental Health and/or Substance Abuse Evaluation and/or Treatment from Behavioral Services Center, P.C.:

Behavioral Services Center.
P.C.

8707 Skokie Blvd., Suite 207 Skokie, IL 60077 188
Industrial Drive, Suite 100 Elmhurst IL. 60126 25980
Diamond Lake Road, Suite 111 Mundelein, IL. 60060 161
North Clark Street, Suite 4700 Chicago IL, 60601 310 South
Greenleaf Street, Suite 205, Park City, IL, 60031

I consent to the use or disclosure of my protected health information by Behavioral Health Services for the purpose of obtaining payment for my health care bills.

By signing this Client Information and Consent Form as the Client or Guardian/Parent of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form, in the Client Rights document, and group rules documents (when applicable) that have been provided to me. I acknowledge that I have been provided with these documents and have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive Mental Health and/or Substance Abuse Evaluation and/or Treatment by clinicians at Behavioral Services Center.

I understand I have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. I understand I have the right to ask questions about any aspects of therapy.

I **, I am consenting to Behavioral Services Center providing me with Mental Health and/or Substance Abuse Evaluation and/or Treatment. I have been provided the Client Rights Document and the Group Rules (when applicable to clients receiving group treatment) and agree to their terms.**

Signature Date

Behavioral Services Center: Criteria For Disqualification

1. If a client arrives more than 15 minutes late to the group session or leaves the group session before the end of the group activities (if applicable), this client will be disqualified from the designated service program.
2. If a client fails to sign into the Attendance Sheet before and/or after class, it will be considered as a client's failure to attend this group session and might lead to the disqualification from the designated service program.
3. If a client arrives more than 15 minutes late to the scheduled group after the break, this client will NOT be allowed to continue participating in this group and it will be considered that this client missed the entire group session, which might lead to the disqualification from the designated service program.
4. If a client refuses to participate in any group-related activity, including a participation in the discussion part.
5. Clients are allowed to have 5 minutes to use the restroom during the group, outside break. If more than 5 minutes will be missed during the group, outside break time, it might be considered that a client skipped class and the disqualification from the designated service program might be considered by the group facilitator.
6. Refusal to test BAL.
7. Use of Drugs/Alcohol before or during groups.
8. Use of electronic equipment (phones, pagers, etc.) during class.
9. Disrespectful behaviors in class towards clients and/or group facilitators.
10. Absence from 3 program groups.

I _____ **, I understand and agree to the Criteria for Disqualification above.**

Signature Date

Behavioral Services Center: Office & Financial Policies

Insurance: The patient/guardian (if applicable) is responsible for knowing their insurance benefit coverage. The Behavioral Services Center will file your insurance claim on your behalf. However, we will not become involved in disputes between you and your insurance regarding coverage and/or policy benefit criteria. We will supply any factual information if necessary. You are responsible for the timely payment of your account.

Self Pay: Payment in full is expected at time of service.

Referrals: It is the patient's responsibility to know if referrals are r equired for specialists visits and to inform their Primary Care Physician. On average, allow 4 business days to p process r referrals.

No shows and late cancellations: We require a 24 hour notice for cancellations. The NO SHOW appointment will result in a missed session charge.

I _____ **, I have read, understand, and agree to the above office financial policies. I hereby also authorize release of information necessary for insurance filing and pre-certification.**

Signature Date

Behavioral Services Center:
Domestic Violence Fee Schedule

Initial Evaluation . . . . . $ 200

Updated Evaluation $150

Individual Counseling/Psychotherapy . . . . . $ 120

DV Group Counseling / Education Group . . . . . $ 50

Outpatient Substance Abuse Treatment Group $50

After Care Group . . . . . $50 / Hour

I _____ accept the above fees of the Behavioral Services Center. I understand that I am responsible to pay the above fees for the received services in full.

Signature **Date**

Behavioral Services Center:
Domestic Violence Contract

I _____ promise to follow the rules of the domestic violence groups in order to be part of the program. Those rules are following:

1. I will be punctual for each session. If I will be late, I will call the agency and have 15 minutes after the hour to arrive to group. If I arrived after the 15 minutes grace period, I will not be allowed to enter to the group and that will be counted as a miss.

2. I will not miss more than three sessions during the whole program, if I miss a session it has to be due to an emergency. If I have an emergency, I have to notify the program. If I do not call, the agency will charge me for the missing session and it will not count toward my treatment hours. If I miss more than two sessions, I will be dropped from the program. If I miss a session, do not call to notify of my absence and /or do not bring proof of my absence, I will pay $ 45.00 for each miss.

3. I will be not be aggressive and will not violate any court order that protects other people.

4. I will notify the facilitators of any legal problem or order of protection where I become involved.

5. I will respect the group members and I will use the appropriate words when I refer to women, my partner or people from other nationalities.

6. I will not reveal any information about the group members.

7. I will talk about myself and my responsibility for my problems without blaming others.

8. I will comply with assigned homework. If I do not comply with it, I will accept that my participation will not count that day.

9. I will not use alcohol or other drugs during the time that I am in the program.

10. I will not possess or bring any weapons to the program.

11. I will sign a consent form to release information for the court, my partner and any other person or agency involved in my case.

12. I will pay for the services weekly and will not fall behind. If I do not come prepared to pay for the session, I will not be allowed to enter the group for the day and that day will be counted as a miss.

13. I will dress appropriately for sessions.

14. It is not permitted to bring children due to fact that the topics are not appropriate for children.

15. I understand that if reports of violence are received from a third party (e.g., family or friend), the staff of the Behavioral Services Center will make every effort to contact the Victim and report this information to the appropriate authorities.

16. I understand that the staff of the Behavioral Services Center immediately reports any threats to do harm or kill to the Victim and monitoring agency, e.g., probation officer, district attorney, or court. I understand that the Victim is notified of any threats of violence I make throughout the course of the intervention.

I am aware of what is expected of me in this program, which is the following:

- ❖ I will understand the different forms of violence that I have used against my partner to control them.
- ❖ That I am the only person responsible for my use violence, the consequences in my partner, children and relatives involved.
- ❖ Be aware of my cultural and social use violence.
- ❖ I will not use violence of any kind in my relationships.
- ❖ I will use non-violent and appropriate methods to resolve any problems and ways to relate with others, especially with women.
- ❖ I will respect the freedom, decisions and feelings of my partner.
- ❖ I will do whatever is possible to rectify the consequences of my violent actions.

Signature **Date**

Behavioral Services Center

Domestic Violence Sign In Sheet

Date of Session	Start Time - End Time	Signature
1.) _____/_____/_____	____:_____ - ____:_____	_____
2.) _____/_____/_____	____:_____ - ____:_____	_____
3.) _____/_____/_____	____:_____ - ____:_____	_____
4.) _____/_____/_____	____:_____ - ____:_____	_____
5.) _____/_____/_____	____:_____ - ____:_____	_____
6.) _____/_____/_____	____:_____ - ____:_____	_____
7.) _____/_____/_____	____:_____ - ____:_____	_____
8.) _____/_____/_____	____:_____ - ____:_____	_____
9.) _____/_____/_____	____:_____ - ____:_____	_____
10.) _____/_____/_____	____:_____ - ____:_____	_____
11.) _____/_____/_____	____:_____ - ____:_____	_____
12.) _____/_____/_____	____:_____ - ____:_____	_____
13.) _____/_____/_____	____:_____ - ____:_____	_____
14.) _____/_____/_____	____:_____ - ____:_____	_____
15.) _____/_____/_____	____:_____ - ____:_____	_____
16.) _____/_____/_____	____:_____ - ____:_____	_____
17.) _____/_____/_____	____:_____ - ____:_____	_____
18.) _____/_____/_____	____:_____ - ____:_____	_____
19.) _____/_____/_____	____:_____ - ____:_____	_____
20.) _____/_____/_____	____:_____ - ____:_____	_____
21.) _____/_____/_____	____:_____ - ____:_____	_____
22.) _____/_____/_____	____:_____ - ____:_____	_____
23.) _____/_____/_____	____:_____ - ____:_____	_____
24.) _____/_____/_____	____:_____ - ____:_____	_____
25.) _____/_____/_____	____:_____ - ____:_____	_____
26.) _____/_____/_____	____:_____ - ____:_____	_____

Dimension 2: Biomedical Conditions:

Behavioral Services Center Medical Form

(Medical History, lab tests if necessary, progress notes, & recommendations)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Information

Last Name:_____First Name:_____Middle Initial: _____

Birth Date: _____/_____/_____ Sex: □ M □ F □ Other Age:

_____

Presenting Problem: _____

Primary Care Physician: _____ Date of last physical exam: ___/____/____

Personal Health History

Childhood Illness (If Applicable): □ Measles □ Mumps □ Rubella □ Polio
□ Chickenpox □ Rheumatic Fever

Immunizations and Dates: □ Tetanus: ___/____/____ □ Hepatitis: ___/____/____
□ Influenza: ___/____/____ □ Pneumonia: ___/____/____
□ Chickenpox: ___/____/____
□ MMR Measles, Mumps, Rubella: ___/____/____

List any medical problems that other doctors have diagnosed: _____

_____

_____

Major Surgeries/Procedures

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Hospitalizations

Year	Reason	Hospital

Prescription/Non-Prescription Drugs

List your prescribed drugs AND over-the-counter drugs, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Allergies to Medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (o.e. Climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (I.e. work or reaction, less than 4x/week for 30 mins)
- ☐ Regular vigorous exercise (i.e. work or reaction 4x/week for 30 minutes)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Number of meals you eat in an average day: _____

Rank salt intake: ☐ High ☐ Medium ☐ Low

Rank fat intake: ☐ High ☐ Medium ☐ Low

Caffeine

Number of cups/cans per day: _____

☐ None ☐ Coffee ☐ Tea ☐ Cola

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind?: _____

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No

Number of years/year quit: _____

☐ Cigarettes - Packs/Day: _____ ☐ Chew - Packs/Day: _____

☐ Pipe - Packs/Day: _____ ☐ Cigars - Packs/Day: _____

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Are you currently using drugs intravenously? ☐ Yes ☐ No

Sex

Are you sexually active? ☐ Yes ☐ No

If yes, are you trying for a pregnancy? ☐ Yes ☐ No

If not trying for a pregnancy list contraceptive or barrier method used: _____

Are you currently pregnant? ☐ Yes ☐ No

Any discomfort with intercourse? ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about risk of this illness? ☐ Yes ☐ No

Personal

Do you live alone? ☐ Yes ☐ No

Do you have frequent falls? ☐ Yes ☐ No

Safety

Do you have vision or hearing loss? ☐ Yes ☐ No

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

Would you like information on the preparation of these? ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

Father:

Age Significant Health Problems

_____ _____

_____ _____

Mother:

Age Significant Health Problems

_____ _____

_____ _____

Sibling:

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Children:

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Age Gender Significant Health Problems

_____ _____ _____

_____ _____ _____

Grandmother (Maternal):

Age Significant Health Problems

_____ _____

_____ _____

Grandmother (Paternal):

Age Significant Health Problems

_____ _____

_____ _____

Grandfather (Maternal):

Age Significant Health Problems

_____ _____

_____ _____

Grandfather (Paternal):

Age Significant Health Problems

_____ _____

_____ _____

MENTAL HEALTH

Have you ever had a TB skin test?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you experience extensive symptoms of stress or nervousness?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Have you ever thought of hurting any other person?	☐ Yes ☐ No
Have you ever been to a mental health professional?	☐ Yes ☐ No
(e.g., psychiatrist, psychologist, counselor, social worker)	☐ Yes ☐ No

TUBERCULOSIS

Have you ever had a TB skin test? ☐ Yes ☐ No

Have you ever had a positive reaction? ☐ Yes ☐ No

Have you ever had Tuberculosis? ☐ Yes ☐ No

If Yes, Have you ever been treated? ☐ Yes ☐ No

Have you ever had contact and/or been exposed to anyone with TB? ☐ Yes ☐ No

Do you have a cough or cold that won't go away? ☐ Yes ☐ No

Have you had a chest X-ray in the past 6 months? ☐ Yes ☐ No

HIV/STD

Are you currently in a relationship? ☐ Yes ☐ No

Have you had "sex" without using a condom? ☐ Yes ☐ No

Have you had sexual contact with someone who has had
sex with someone other than yourself? ☐ Yes ☐ No

Have you had a blood transfusion between the years of 1977-1985? ☐ Yes ☐ No

Have you been tested positive for a STD (including Hepatitis)? ☐ Yes ☐ No

Have you had sexual intercourse with anyone who has HIV? ☐ Yes ☐ No

If you answered "Yes" to any of the last five questions, we recommend that you get tested for HIV.

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

☐ Skin : _____

☐ Head/Neck : _____

☐ Ears : _____

☐ Nose : _____

☐ Throat : _____

□ Lungs : _____

□ Chest/Heart : _____

□ Back : _____

□ Intestinal : _____

□ Bladder : _____

□ Bowel : _____

□ Circulation : _____

Recent Changes In:

□ Weight : _____

□ Energy Level : _____

□ Ability to Sleep : _____

□ Other pain/discomfort: _____

NOTES:

Behavioral Services Center:
Psycho-Social Screening History

Please answer the following questions to the best of your ability.

Family Substance Abuse History:

History of concurrent psychiatric symptoms, complications, or conditions (including sleeping and eating habits):

Medications:

Support System and Current Coping Skills:

Suicide/Homicide Potential:

Developmental History:

Highest Level of Education:

Marital Status/History:

Living Situation:

Employment History (Including Salary Information):

Legal History:

Psychiatric Treatment History:

History of Trauma (Including Physical and/or sexual abuse): ☐ Yes ☐ No
If yes, please explain the history of recent trauma:

Additional Special Accommodations Requirements other than English Communication Needs:

Behavioral Services Center:
Perpetrators Of Partner Abuse Assessment/Intake

Your relationship to victim:

Kind of Abuse:

▢ Psychological/Emotional ▢ Physical ▢ Sexual

▢ Economic ▢ Threat of Physical ▢ Threat of Sexual Coercion ▢ Stalking/Isolation/Control

Length of Involvement:

How did you meet?

Were you using drugs and/or alcohol at the time of the offense?

Was your partner using drugs and/or alcohol at the time of the offense?

Are you still involved with the individual?

Are you currently involved in an intimate relationship? If so, with who and how many?

Describe the most violent event between you and your partner:
What did you and your partner fight about most?

How do you deal with the end of a relationship?

How does your partner deal with the end of a relationship?

Have your friends/co-workers/family members expressed concern about your relationship?

Are you afraid of your partner?

▢ Never ▢ Sometimes ▢ Always

If Sometimes or Always, please specify specifically when:

Is your partner afraid of you?

▢ Never ▢ Sometimes ▢ Always

If Sometimes or Always, please specify specifically when:

To what extent has law enforcement been involved due to fighting or abuse?

In this incident who called the police?

In other incidents who called the police?

Is there now, or has there ever been, an Order of Protection against you? If so, please explain:

Is there now, or has there ever been, an Order of Protection against your partner? If so, please explain:

Have you ever been arrested? If so, Please explain:

To the best of your knowledge, has your partner ever been arrested? If so, Please explain:

Have you ever been sentenced by a court for a crime? If so, Please explain:

Have you ever used a weapon during a fight? If so, Please explain and include what kind:

Has your partner ever used a weapon during a fight? If so, Please explain and include what kind:

Why do you think you are here today?

What do you think are your greatest strengths?

Is there anything else about you, your partner, or your relationship you would like to share?