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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Client Information

Name	Date	Client Number	Insurance Number
FOR OFFICIAL USE ONLY:			
Client Number	Effective Date	Insurance No	OH No

CLIENT INFORMATION

Client name	Date of birth
Name of significant other	Date of birth

CHILDREN INFORMATION

Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth
Name	☐ Full	☐ Half	☐ Step	☐ Adopted	Date of birth

OTHERS IN CLIENT'S LIFE

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

REFERRED FOR [Please check one]:	☐ Therapy	☐ Parent Therapy Group	☐ Case Management	
PAYMENT OPTION [Please check one]:	☐ Medicaid	☐ Self Pay	☐ Private Insurance	
☐ New Client [Please check one]:	☐ CCSS	☐ Therapy	☐ Medicaid	☐ Other
☐ Returning Client [Please check one]:	☐ CCSS	☐ Therapy	☐ Medicaid	☐ Other

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1.2 ADULT CLIENT INTAKE FORM: Notice of Privacy Practices

Name | Date | Client Number | Insurance Number

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

At All Faiths, we protect the confidentiality of your medical and mental health information. Protected Health Information (PHI) is information that may identify you. It relates to your physical or mental health conditions and related health care services. This notice describes how All Faiths may share medical information about you and how you can have access to this information. Please review it carefully. Should you require more specific information, please ask us. For more information on the law, please go to: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Your Rights

- Know how we use and how we protect your PHI.
- Correct your paper or electronic medical record
- Ask us to limit the information we share
- Get a copy of this privacy notice
- Get a copy of your paper or electronic medical record
- Request confidential communication
- Get a list of those with whom we've shared your information
- Choose someone to act for you

Your Choices

For certain health information, you can tell us your choices about what we share. In these cases, you have both the right and choice to tell us to:

- Share your PHI with your family, close friends, or others involved in your care
- Share your PHI in a disaster relief situation
- Provide mental health care

We never share your PHI unless you give us written permission or for the exceptions below. All Faiths never sells personal information.

Our Uses and Disclosures

We may use and share your PHI, as we:

- Treat you
- Bill for your services
- Do research
- Address workers' compensation, law enforcement, and other government requests
- Run our organization
- Help with public health and safety issues
- Comply with the law
- Respond to lawsuits and legal actions

More specifically, we may use or share your PHI in the following situations without your authorization or opportunity to object:

- Protection of public health & safety
- Prevention of individual risks of communicable diseases
- Activities of health oversight agencies
- Other requirements by law
- Risk of harm to self or others
- Reports of child abuse or neglect
- Response to legal proceedings

Complaints

You may complain to us or to the Secretary of Health and Human Services, if you believe that your privacy rights have been violated by us. All Faiths has a Privacy Officer, who ensures that we follow our policy to protect your health information.

If you have questions or concerns about the privacy of your information or wish to read our more detailed policy, you may contact our Privacy Officer, Krisztina Ford, CEO at All Faiths at kford@allfaiths.org or 505-271-0329. This notice reflects federal changes to the HIPAA laws as of September 2013 and is effective October 2014.

By signing here I acknowledge that I've been informed of the above:

Signature | Date

Client or Authorized Representative

Signature | Date

Intake Therapist

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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Consent for Services

Name	Date	Client Number	Insurance Number

CONSENT FOR SERVICES

Welcome to ALL FAITHS

We have been caring for people affected by childhood and family trauma since 1956. All Faiths is committed to providing a child and family-friendly system of care that serves your needs. We seek to provide professional, high quality services with dignity, respect, and hope. Please read this Consent for Service document to understand our approach to providing care.

Treatment Planning

As an individual/family seeking services, you have the right to:

- Fair and ethical treatment
- Participate in the development of your treatment/service plan
- Refuse consent for treatment, special projects, or any aspect of the treatment/service plan
- Be referred to other providers, if you desire different or additional services

Partnership

We believe that both receiving and providing services is a partnership. In making your commitment to receive services, consider the guidelines below pertaining to both you and All Faiths' staff.

- CONTACT INFORMATION: You agree to share and update your family contact information with All Faiths' staff. All Faiths will share how to contact us at any time.
- TREATMENT: It is necessary and helpful for you, your family and All Faiths' staff to cooperate in creating goals, action steps, and a treatment/service plan, which you are committed to follow.
- COMMITMENT: It is an equal commitment for both families and All Faiths to follow through on scheduled appointments and notify one another of cancellations.

Continuous Quality Improvement

All Faiths is interested in your feedback and ideas about how to improve our agency and our services. We request your permission to ask about your satisfaction with our agency, staff and services.

Confidentiality

You are expected to maintain the confidentiality of information shared, including the identity of other program participants. In our commitment to you, we will review with you, our information sharing processes under the Health Insurance Portability and Accountability Act (HIPAA).

All Faiths will:

- Provide you with our Notice of Privacy Practices that describe your right to copy, inspect, and amend your file
- Provide information and education concerning the uses and disclosures of your PHI
- Obtain an informed consent from you regarding this consent for services document as evidenced by your signature on this consent
- Report, as required by law:
  1 Suspected child abuse or neglect, and
  2 Clear evidence of planned or committed acts of violence against self or others.

Written Records and Complaints/Grievances

Our Notice of Privacy Practices addresses your right to complain about breaches of privacy or security concerning your PHI. We encourage you to review your rights and discuss concerns with your service provider, their supervisor, management and/or all Faiths' Privacy Officer. If the issue is not resolved to your satisfaction, follow the detailed grievance procedure given to and signed by you.

In some circumstances, case files may be subpoenaed. Such cases usually involve a dispute of which you would be well aware.

Emergencies

All Faiths offers 24-hour crisis intervention line to our clients, which will be further reviewed with you in your intake and treatment sessions. If your concern involves violence against self or others or a medical emergency, go to an emergency room, psychiatric hospital, or call 911.

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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Consent for Services [continued]

Name	Date	Client Number	Insurance Number

CONSENT FOR SERVICES [continued]

Funding for Services

All Faiths provides therapeutic services at the most affordable rate possible depending on level of insurance coverage. Each funding source has unique requirements, which we must follow.

- Diagnostic information is shared when we charge services to:

1 Medicaid
2 Non-Medicaid funding from the state of New Mexico general fund dollars appropriated to Children, Youth, and Families Department or other state agencies
3 New Mexico Crime Victims Reparation Committee (NMCVRC)
4 Private Insurance

Client or guardian is responsible for payment of all applicable fees.

Consent for Services

By my signature below, I acknowledge the following:

- I have read (or have had read to me) and understand my rights and responsibilities as outlined above.
- I consent to All Faiths providing behavioral health services to myself and/or my dependents.
- The information concerning my financial resources, Medicaid, or NMCVRC benefits is correct, and I agree to inform All Faiths of any changes.
- I understand that I am fully responsible for any fees charged for behavioral services provided to myself or my dependents, who are a part of this agreement. If I leave All Faiths with an unpaid balance, All Faiths will make every effort to collect these debts.
- I give consent to All Faiths for emergency medical treatment, if needed.
- I give permission that All Faiths may contact me by telephone, in writing or person, for feedback about my experience.
- I may withdraw this Consent at any time.

The following list of people are considered and acknowledged to be covered by this agreement:

1 Name	2 Name
3 Name	4 Name
5 Name	6 Name

Signature	Date

Client or Authorized Representative

Signature	Date

Intake Therapist

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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Fee for Service

Name | Date | Client Number | Insurance Number

FEE FOR SERVICE

Fees are an important issue to anyone receiving professional therapeutic services. This fee for service agreement was prepared to clarify fees and payment issues. For child clients with separate guardians, this document will reflect a combination of all insurance coverage for the child (and therefore may need to be revised if information is gathered after the initial intake). Insurance providers are billed in the following order: Private Insurance, Medicaid, and lastly VOCA.

1 We accept certain private insurances. You will be informed if we accept your private insurance. Co-pays and/or deductibles must be paid at the time of service. Private Insurance Carrier (Please provide a copy of your card, both front and back sides):

Insurance company | Policy holder | Policy number

Copay amount | Deductible amount

NOTE: MEDICAID RULES REQUIRE THAT WE BILL PRIVATE INSURANCE FIRST.

2 We accept Medicaid reimbursement rates with no out of pocket expense to the client or family unless you have a co-pay. Co-pays must be paid at the time of service.

MCO [Please check one]: ☐ Pres/Magellan ☐ Molina ☐ United Healthcare ☐ BCBS

Name of policy holder: | Medicaid number | Co payment amount

NOTE: PRIVATE INSURANCE AND MEDICAID MUST BE BILLED PRIOR TO BILLING VOCA.

3 We accept VOCA reimbursement rates as a payer of last resort for the client (excluding FAMILY THERAPY sessions without client present) if you have an approved VOCA documentation.

Has a VOCA application been completed? [Please check one] ☐ Yes ☐ No

Have you been approved as a VOCA client? [Please check one] ☐ Yes ☐ No

4 You are responsible for the full standard amount for services provided if any of the following is true:
a-The only insurance coverage is a private insurance that we do not accept
b-The private insurance or Medicaid insurance coverage expires
c-The deductible for the private insurance is not met.

5 Law requires that all clients must have some sort of health insurance. Therefore, All Faiths no longer utilizes a sliding fee scale. If you choose to not carry insurance or your insurance coverage lapse, you will be required to pay the full amount of service cost at the time of service unless you sign a payment plan agreement with our Finance Department.

We have discussed your fees, payment options, and financial situation and have reached an agreement regarding fee for services. **Fees are due at the time that service is provided.** By signing below, all responsible parties agree to the terms and conditions on page one of this document:

Signature | Date

Client or Authorized Representative

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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Client Grievance Policy and Procedures

Name	Date	Client Number	Insurance Number

CLIENT GRIEVANCE POLICY AND PROCEDURES

Client Grievance Policy

All Faiths provides a grievance response protocol in the event a client or family member chooses to file a complaint or grievance with the agency. The conditions for expressing a grievance are clearly stated and presented to the client/family member in a fair, and non-intimidating, manner.

This grievance procedure allows clients to appeal staff service delivery decisions up the supervisory ladder of the All Faiths program. As a further guarantee of clients' rights, this policy also outlines a procedure to allow a client an "advocate". The advocate may represent the client, at the client's request. The client has the right to request an individual who is not associated with All Faiths to act as advocate. The All Faiths organization will not be responsible for the cost of an advocate's service.

Client Grievance Procedures

1 Written grievance procedures shall be given, and clearly explained, to the All Faiths client upon the client's request. A notice that Client Grievance Procedures exist will be posted. These materials shall include the procedure for securing the services of an "advocate".

2 There will always be an initial attempt, by a client and Supervisor, to resolve any disputes between the two parties.

3 The client may request the assistance of a "client advocate" or any representative of his/her choice at any time after attempts to resolve the dispute with the Program Supervisor. The client advocate may assist the client in preparations for meeting or may actually present the client's case at meetings. The client must be present at all grievance meetings, whether or not client advocate presents the client's case.

4 If the grievance is not resolved to the client's satisfaction after meeting the Supervisor, the client may ask for an appeal of the decision to the Director. This request for an appeal must be in writing.

- A meeting with the client, client advocate, Supervisor and Director shall be promptly arranged in order to resolve the dispute. This meeting shall occur no later than three (3) working days after the client's written request is received by the Director.
- A written summary of the dispute shall be made prior to the meeting with the Director. The client shall be given an opportunity to write a summary. The Supervisor will also be responsible for writing a summary. Copies of the summaries shall be kept by the client, placed in the client's records and sent to the CEO.
- The Director's decisions shall be in writing, with copies placed in the client's file and sent to the client, no later than five (5)working days after the meeting.

5 If the grievance is not resolved to the client's satisfaction after meeting with the Director, client may appeal the decision to All Faith's CEO. This request must also be in writing.

- A meeting with the client, client advocate, Director and CEO shall be promptly arranged in order to resolve the dispute. Such a meeting shall occur no later than three (3) working days after the CEO receives the client's request.
- The CEO's decision shall be in writing, with copies placed into the client's record and sent to the client, no later than ten (10) working days after the meeting. The CEO's decision is final.

I have read and understand the procedures to take if I have a grievance against All Faiths' staff.

Signature	Date
Client or Authorized Representative	

Signature	Date
Witness	

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ALL FAITHS

1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment

Name	Date	Client Number	Insurance Number

CLIENT HOME LIFE: ADDENDUM No: 1

Client name	Date of birth

FAMILY COMPOSITION [Who lives in the home with the client]

Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender
Name	Relationship	Date of birth	Gender

OTHER SIGNIFICANT FAMILY MEMBERS

• Name	Relationship	Date of birth
Address		
• Name	Relationship	Date of birth
Address		
• Name	Relationship	Date of birth
Address		
• Name	Relationship	Date of birth
Address		

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1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment [continued]

Name | Date | Client Number | Insurance Number

CLIENT HOME LIFE: ADDENDUM No: 1 [continued]

LIST PLACES OF RESIDENCE FOR CHILD OTHER THAN WITH PARENTS

- Date from | Date to | Age | Lived with

Reason for not living with parents

- Date from | Date to | Age | Lived with

Reason for not living with parents

- Date from | Date to | Age | Lived with

Reason for not living with parents

- Date from | Date to | Age | Lived with

Reason for not living with parents

FAMILY PRACTICES

Are there events that are important to the client and/or family? What do you do together as a family? Please explain:

FAMILY SPIRITUALITY

What religion is the client?

Do you attend church or religious ceremonies as a family? Please explain.

Is there anything about the family home life that would be important for us to know?

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1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment [continued]

Name	Date	Client Number	Insurance Number

TREATMENT INVENTORY: ADDENDUM No: 2

Behavioral Health Treatment History:

Please list in the table below any other behavioral health service (eg therapy, case management, psychiatry, residential treatment, MST) that the client has received. If none, please go to the next section.

• Date of Service:	From	To
Service description		
Name of service provider/agency		
• Date of Service:	From	To
Service description		
Name of service provider/agency		
• Date of Service:	From	To
Service description		
Name of service provider/agency		
• Date of Service:	From	To
Service description		
Name of service provider/agency		

Therapy Needs or Preferences:

What days and times do you prefer for an appointment?	Day	Time
Please be advised that there is a long wait for evening and Saturday appointments.		
Do you prefer male or female service provider?	☐ Female	☐ Male
Do you prefer a therapist or case worker?	☐ Therapist	☐ Case worker
Do you need a Spanish-speaking therapist?	☐ Yes	☐ No
If one is not available, can you manage with an English-speaking therapist?	☐ Yes	☐ No
Are any of your family members currently seeing a therapist at All Faiths?	☐ Yes	☐ No
If yes, please provide name/names here?		
If yes, would you like to see the same provider?	☐ Yes	☐ No
Is there any other information that you want to share to guide us in the selection of your therapist?		

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1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment [continued]

Name	Date	Client Number	Insurance Number

CLIENT MEDICAL HISTORY: ADDENDUM No: 3

Name of primary care provider		Phone	
Client height	Weight	Hair color	Eye color

Are all immunizations up to date? ☐ Yes ☐ No

If not, please explain.

Date of last physical exam — Date of last dental exam

Allergies: Please list all foods or medicines that the client has allergies to:

1 Allergic to:	☐ Mild	☐ Moderate	☐ Severe	Epi-pen needed	☐ Yes	☐ No
2 Allergic to:	☐ Mild	☐ Moderate	☐ Severe	Epi-pen needed	☐ Yes	☐ No
3 Allergic to:	☐ Mild	☐ Moderate	☐ Severe	Epi-pen needed	☐ Yes	☐ No
5 Allergic to:	☐ Mild	☐ Moderate	☐ Severe	Epi-pen needed	☐ Yes	☐ No
6 Allergic to:	☐ Mild	☐ Moderate	☐ Severe	Epi-pen needed	☐ Yes	☐ No

Mobility Issues

Does the client or any one that will be with the client at All Faiths use an assistive device such as a wheel chair, crutches, brace, or walker? ☐ Yes ☐ No

Health Issues: Check all that apply:

☐ Vision problems	☐ Hearing problems	☐ Sinus/Seasonal allergies
☐ Dizziness	☐ Asthma/Respiratory problems	☐ Headaches
☐ Diabetes	☐ Seizures	☐ Head injury history
☐ Wetting or soiling accidents	☐ Anemia or Blood disorder	☐ Heart problems
☐ Frequent urinary infections		

Please explain any health issues checked above:

How often do you exercise and what do you do for exercise?

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1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment [continued]

Name | Date | Client Number | Insurance Number

CLIENT MEDICAL HISTORY: ADDENDUM No: 3 [continued]

Nutrition & Weight Issues

Are you on a special diet? ☐ Yes ☐ No

If yes, please explain

Do you have a healthy appetite? ☐ Yes ☐ No

If no, please explain

Have you experienced any changes in weight in the last 3 months? ☐ Yes ☐ No

If yes, please explain

How would you describe your body? ☐ Obese ☐ Healthy weight ☐ Emaciated ☐ Other

Do you binge eat or vomit after meals regularly? ☐ Yes ☐ No

If yes, please explain

Sleep Issues

How many hours do you sleep a night?

Do you have problems falling asleep or staying asleep? ☐ Yes ☐ No

If yes, please explain

Do you have nightmares? ☐ Yes ☐ No

If yes, please explain

Current Medications: Please list in the table below any medications that the client is currently taking

	Medication Name	Dosage	Reason prescribed	Prescribing doctor
1				
2				
3				
4				
5				

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1.2 ADULT CLIENT INTAKE FORM: Comprehensive Psychosocial Assessment [continued]

Name	Date	Client Number	Insurance Number

CLIENT MEDICAL HISTORY: ADDENDUM No: 3 [continued]

Past Medications: Please list in the table below any medications that the client previously took

1	Medication Name	Dosage	Reason prescribed	Prescribing doctor
2	Medication Name	Dosage	Reason prescribed	Prescribing doctor
3	Medication Name	Dosage	Reason prescribed	Prescribing doctor
4	Medication Name	Dosage	Reason prescribed	Prescribing doctor
5	Medication Name	Dosage	Reason prescribed	Prescribing doctor

Any side effects or problems while taking current or past medications? ☐ Yes ☐ No

If yes, please explain

