New Chart Checklist - Adolescent

Client Name: _____ ID No: _____

_____ Referral Form

_____ Client ID/ Emergency Contact Sheet

_____ Consent to Treatment for minor

_____ Explanation of Confidentiality

_____ Bill of Rights and Responsibilities

_____ General Release of Information

_____ Safety Plan

_____ School Authorization Form

_____ Biopsychosocial Assessment

_____ Treatment Plan

_____ Transition and Discharge Plan

_____ Trauma Assessment Summary Form

_____ _____

Clinician Signature Date

Client Initials: _____ DOB: _____

Consumer Identification/Emergency Contact Sheet

Identifying Information

Consumer Name: _____

Date of Birth: _____ Gender: _____ Race: _____

Social Security Number: _____

Address: _____

Home No.: _____ Cell No. : _____

Parents/Legal Guardian Name: _____

Address: _____
(If different than above)

Allergies: _____

Emergency Contacts

Name: _____

Relationship to consumer: _____

Contact Number: _____

Name: _____

Relationship to consumer: _____

Contact Number: _____

Client Initials: _____ DOB: _____

Agreement for Counseling with a Minor

I, _____, the parent/legal guardian of minor, give my permission for this minor to receive the following services from TRUTHERAPY, LPC.

1. Assessment
2. Individual, Family, and Group Counseling
3. Case Management
4. Community Support and IFI Services
5. Psychiatric and Nursing Services
6. Transportation
7. Other Services (specify)_____

These services are for the purpose (s) of:

_____
_____
_____

The Agency's policies concerning missed appointments have been explained to me. I have been told about the risks and benefits of receiving these services, for both this minor and their family.

I understand that this professional may also interview, assess, or treat these other persons:

1. _____
2. _____

Because of the laws of this state and the guidelines of the clinician's profession, these rules concerning privacy will be used:

- ✓ Issues discussed in counseling will be held confidential with the exception of, the Limits of Confidentiality.
- ✓ A report or reports concerning the counselor's finding will be available, as requested by probation, court and/social services.
- ✓ Progress in this minor's treatment will be reviewed every 30 days. Minor's parent/legal guardian must sign a release of information before any information can be released.
- ✓ I give my permission for the therapist to audiotape/videotape our sessions for personal review and use with a consultant, who is also bound by the legal framework of privacy and confidentiality.
- ✓ I understand that any information in this recording that could identify me in any way will not be published or given out without my written consent.

My signature means that I understand and agree with all of the above.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

I, _____have discussed the issues above with the minor client's guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client's treatment.

 Client Initials: _____ DOB: _____

Limits of Confidentiality I

The contents of a counseling, intake, or assessment session are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this organization not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. In addition, it may be necessary for the health care professional to take steps for the client to be placed in a restricted hospital environment to ensure the safety of the client and of others.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse or neglect, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Other health care professionals must report professional misconduct by a health care professional. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed. Clients who are on probation, court ordered to treatment or referred by the Department of Juvenile Justice, Department of Human Resources or the county Juvenile Court may have waived certain rights to confidentiality when entering the treatment program.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Client Initials: _____ DOB: _____

Limits of Confidentiality II

Audio/Video Taping

In the event it becomes necessary to audio and/or video tape a client for treatment or supervision purposes, a specific consent form for audio and/or video will be required. No recordings of any kind will be conducted without the expressed consent of the client.

Other Provisions

This agency does not conduct research on any of their clients. Outcome measures, as it pertains to the effectiveness or non-effectiveness of the treatment services are collected and analyzed to ensure that the best quality treatment is provided. No personal information on any client is disclosed, nor can any client be identified by any of outcome information collected.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couple's sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the company or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name or the nature of the call, but rather the mental health professional's first name only.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist Signature and Credentials Date

Client Initials: _____ DOB: _____

Client Bill of Rights and Responsibilities

1. The client has the right to make informed decisions regarding his/her care and participate in decisions regarding care, including the development and revisions of the plan of treatment (COA: G.1.02.e), the client shall receive information necessary to make decisions regarding his/her care and is expected to work with Clinician toward set treatment plan and goals (COA: G1.1.02. a).
2. It is the expectation of this therapist that the client makes every effort to keep scheduled appointments. Missed appointments (without adequate rationale) will result in a warning that can be followed by termination of services. It is the policy that client can have no more than three missed appointments before termination of services. Any blatantly offensive, threatening or violent behavior could result in termination of services. (COA: G1.1.02.c).
3. The client is responsible for paying his/her portion of charges at time of service. The client shall be referred to alternate services, if available, when therapist is unable to meet identified client needs. The client shall be informed in a timely manner of the need to transfer to another organization and/or level of care and of the alternative, if any to such transfer.
4. All information concerning client treatment shall be treated confidentially within the confines of Georgia law. As required by law, the therapists are mandated reporters and are required to report situations in which an individual is a danger to themselves or others. Information will not be released to any organizations/individuals (outside of the referring agency) without the written consent of the client (COA: G1.5.03).
5. The client shall be informed upon acceptance the mechanism for receiving, reviewing and resolving client complaints by contacting therapist or administration (COA: G1.1.02. f). The client has the right to insert a statement, in their own words, into their case record. If personnel inserts a statement in response the client has the right to review it.
6. If the client experiences an emergency which constitutes as a situation where there is a high or elevated risk of harm or threat of harm to his/her life the client is to seek emergency support by **FIRST dialing 911 and contacting the police or report to the nearest emergency room.** The therapist is not responsible or liable if the client does not comply with this request of the therapist.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature and Credentials Date

Client Initials: _____ DOB: _____

TRUTHERAPY

School Authorization Form

I, _____ (PARENT/LEGAL GUARDIAN NAME), the parent/legal guardian of _____ (CLIENT'S NAME), give permission for mental health providers at Trutherapy LPC to provide counseling and other related services for my child at _____ (NAME of SCHOOL). They also have permission to meet with teachers and other school officials to discuss my child.

I also give _____ (NAME OF COUNSELOR) permission to pick-up my child from school in order to provide the services he/she needs.

If you have any questions or concerns please feel free to contact me at:
_____ (PARENT/GUARDIAN CONTACT NUMBER)

_____ _____
Parent/Guardian Printed Name Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature & Credentials Date

Client Initials: _____ **DOB: _____**