GREAT PLAINS YOUTH & FAMILY SERVICES, INC.

901 S. BROADWAY
HOBART, OKLAHOMA 73651
580.726.3383
FAX: 580.726.3384
WWW.GPYFS.ORG

ADULT INTAKE ASSESSMENT

Date:_____

1. Identifying Information

Last Name: _____ Maiden: _____ First Name: _____ MI: _____

Address: _____ City: _____ County:_____ State: _____ Zip: _____

Home Phone: _____ Work : _____ Cell Phone: _____ Carrier: _____

Email: _____ SSN: _____ DOB: _____ Place of Birth: _____

Marital Status: ☐Divorced ☐Living as Married ☐Married ☐Never Married ☐Separated ☐ Widowed

Height: _____ft. _____in. Weight: _____ lbs. Eye Color: _____ Hair Color: _____ Gender: ☐M ☐F

Appointment Reminders: ☐Email ☐Text Message ☐Voice Mail ☐None

In Case of an Emergency

1. Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell Phone: _____

Relationship: _____ Email: _____ ☐Legal Guardian ☐Emergency Contact

2. Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell Phone: _____

Relationship: _____ Email: _____ ☐Legal Guardian ☐Emergency Contact

Cultural Orientation

Race/Ethnicity: (Select one only) ☐White/Caucasian ☐Black/African American ☐Native American ☐Hispanic/Latino ☐Asian ☐Mixed Race ☐Hawaiian/Pacific Islander

Tribal Affiliation

☐No Tribal Affiliation ☐Member of: _____

Insurance

Primary: ☐CARS ☐CBYS ☐DMH ☐EPSDT ☐IHS ☐Medicaid ☐Medicare ☐BCBS ☐HealthChoice ☐TriCare ☐Private Pay ☐Other: _____ Deductible: _____ CoPay: _____

Primary Policy Holder: _____ Policy #: _____ Prior Auth Phone: _____

Secondary ☐CARS ☐CBYS ☐DMH ☐EPSDT ☐IHS ☐Medicaid ☐Medicare ☐BCBS ☐HealthChoice ☐TriCare ☐Private Pay ☐Other: _____ Deductible: _____ CoPay: _____

Secondary Policy Holder: _____ Policy #: _____ Prior Auth Phone: _____

Tertiary Policy Holder: _____ Policy #: _____ Prior Auth Phone: _____

Client: Last Name: _____ **First:** _____ **MI:** _____

Why are you seeking counseling? _____
_____
_____
_____
_____
_____
_____

2. Medical History

Health Care Information/Resources

Primary Care Physician: _____ Designated Hospital: _____

Allergies/Adverse Reactions/Alerts

☐No Known Medication Allergies ☐No Known Food Allergies

Substance	Reaction	Severity *(Mild/Moderate/Severe)*	Status *(Active/Inactive/Unspecified)*	Started

Hearing/Vision

Hearing Screening Date: _____ Vision Screening Date: _____

☐Pass ☐Fail ☐Aided ☐Pass ☐Fail ☐Aided

Current Medical Conditions/Complications

☐Client is pregnant Estimated Due Date: _____ Prenatal Care Needed: ☐Yes ☐No

Describe Medical Conditions/Current Diagnosis: _____
_____

History of Medications and Current Medications

Physician Prescribed	Medications	Type *(Circle)*	Dosage/ Strength	Frequency of Medication	Start Date	Side Effects	Reason or Benefit	Current/Past Medication *(Circle)*
1.		Rx OTC						Current Past
2.		Rx OTC						Current Past
3.		Rx OTC						Current Past
4.		Rx OTC						Current Past

Developmental History

Were developmental age factors, motor development, and functioning accomplished within appropriate time frames?

☐Yes ☐Unknown ☐No

If YES, explain: _____
_____
_____
_____

Handicaps/Disabilities/Limitations/Challenges

Are you experiencing any chronic medical, ambulatory, speech, hearing, or visual functioning problems?

☐ None ☐Semi-ambulatory ☐Non-ambulatory ☐Severe Sight Disability ☐Blind
☐Organic Based Communication Disability ☐Chronic Health Problems
☐Mental Retardation/Developmental Disability ☐Hard of Hearing ☐Deaf ☐Interpreter for the Deaf

Client's adjustment to disabilities or disorders: _____
_____
_____

3. Mental Health History

Treatment

How many times have you been treated for any psychological, or emotional problems, or substance abuse?
In hospital or inpatient setting: _____ Outpatient/private patient setting: _____

Location of Treatment	Type of Treatment *(Hospital, Day Treatment, Outpatient, School)*	Dates of Treatment	Length of Treatment	Type of Care *(Psychological, Emotional, Substance Abuse, Alcohol, DV, Gambling)*
1.				
2.				
3.				

History of Suicide Attempts

How many suicide attempts? _____ Date of last attempt: _____

Method of suicide attempt: _____
_____
_____

In the past 90 days, how many incidents of self-harm have occurred? _____

Is there a family history of suicide? ☐ Yes ☐ No

Are there firearms in the home? ☐ Yes ☐ No If yes, are they locked up? ☐ Yes ☐ No

4. Behavioral History

Sexual History - *Including HIV/AIDS & STD At-Risk Behaviors*

☐Client refused to answer ALL questions regarding sexual history

Age began dating: _____ ☐Not yet dating Age began sexual activity: _____ ☐Not yet sexually active

Sexual Orientation: ☐Heterosexual ☐Bisexual ☐Homosexual ☐Transgender ☐Questioning

Gender Expression/Orientation: ☐Masculine ☐Androgynous ☐Feminine ☐Other _____

Are you currently sexually active? ☐Yes ☐No ☐Refused to answer

Tobacco/Nicotine Use

Have you ever used tobacco? ☐Yes ☐No Age first used tobacco: _____ Age first regular use? _____

Do you currently smoke? ☐Yes ☐No Years of daily use? _____

If yes, how many times per day do you use tobacco? _____

Alcohol Use

Have you ever used alcohol? ☐ Yes ☐No Age first used alcohol: _____

Have you ever used alcohol to intoxication? ☐Yes ☐No Age of first intoxication: _____

Have you used alcohol in the past 30 days? ☐Yes ☐No

Have you used alcohol to intoxication in the past 30 days? ☐Yes ☐No

Have many times have you had Alcohol Delirium Tremens *(DT's)*? _____

Drug Use

Have you ever abused any drug? ☐Yes ☐No

If yes, check which drugs you have abused and what age you first used them.

Drug Name	Age	Drug Name	Age	Drug Name	Age
☐Amphetamine		☐Barbiturates		☐Benzodiazepine	
☐Club Drugs		☐Cocaine		☐ Heroin	
☐Inhalants		☐Marijuana/Hashish		☐ Methamphetamine	
☐ Non-Rx Methadone		☐ Other Amphetamine		☐Other Hallucinogens	
☐Other Opiates/Analgesics/ Synthetics		☐Other Sedatives/ Hypnotics		☐Other Stimulants (Caffeine)	
☐Other Tranquilizers (Ketamine)		☐Over the Counter		☐PCP	
☐Other: _____		☐Unknown			

Have you ever abused any substance by injection/needle? ☐Yes ☐No

How many times have you overdosed on drugs? _____

Current Drug Usage

Current frequency of use: *P=Primary Drug of Choice; S=Secondary Drug of Choice; T=Third Drug of Choice*
1 = No Past Month Use 2 = 1-3 Times/Month 3 = 1-2 Times/Week 4 = 3-6 Times/Week 5 = Daily

Amphetamine _____ Barbiturates _____ Benzodiazepine _____ Club Drugs _____ Cocaine _____ Heroin _____
Inhalants _____ Marijuana/Hashish _____ Methamphetamine _____ Non-Prescription Methadone _____ PCP ____
Other _____ Other Amphetamine _____ Other Hallucinogens _____ Other Opiates/Analgesics/Synthetics _____
Other Sedatives/Hypnotics _____ Other Stimulants _____ Other Tranquilizers _____ Unknown _____ OTC _____

Other Behavioral Addictions

Do you have a history of other at-risk behaviors? ☐Yes ☐No

If yes, check all that apply: ☐Eating Disorder ☐Excessive Shopping ☐Exercise ☐ Sex ☐Self-mutilation
☐Pornography ☐ Gambling ☐Other: _____

If any of the above are checked, please describe its impact on your life: _____
_____
_____

Family History of Alcohol or Drug Use

Have any of your family members had a drinking, drug, or psychological problem? *(Insert name in blank areas)*

Spouse: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Father: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Step-Father: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Mother: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Step-Mother: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Grandparent: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Sibling: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem
Sibling: _____	☐Alcohol Problem	☐Drug Problem	☐Psychological Problem

Orientation to Change

Describe how at-risk behaviors have resulted in changes in your life: _____
_____
_____
_____

Legal

Legal Papers in File: ☐Mental Health Advance Directive ☐Living Will ☐DNR

Legal Status: ☐Federal County of Jurisdiction/Commitment: _____

☐Community Sentencing
☐Court Commit with Hold (CC-H)
☐Court Order for Observation and Evaluation
☐Court Voluntary
☐Emergency Detention
☐Order of Detention
☐Protective Custody
☐Twenty-Eight Day Court Commitment
☐Voluntary Admission
☐Continued Court Detention
☐Court Commitment
☐Court Referred (DUI)
☐Criminal Hold (CR-H)
☐Informal Admission/None
☐Not Guilty by Reason of Insanity (NGRI)
☐Other
☐Transfer – Other Legal Entities

Custody /Referral Type

Do you have a Probation or Parole (P&P), or OJA/DHS Case Worker? ☐Yes ☐No

☐APS Case ID#: _____ ☐DHS/CW Case ID#: _____
☐Felony Drug Court Case ID#: _____ ☐Federal P&P Case ID#: _____

P&P Officer/OJA/DHS Case Worker Name: _____
Phone Number: _____ Case Number: _____
Address: _____ City: _____ County: _____
State: _____ Zip: _____

How many times have you been arrested in the past twelve *(12)* months? ____
Of those arrests, how many have occurred in the past 30 days? _____

Legal History

Offenses (Start with the most recent)

1. Date: _____ City/State: _____
Type: ☐Misdemeanor ☐Statutory ☐Felony
Charge: _____
Outcome: _____

2. Date: _____ City/State: _____
Type: ☐Misdemeanor ☐Statutory ☐Felony
Charge: _____
Outcome: _____

3. Date: _____ City/State: _____
Type: ☐Misdemeanor ☐Statutory ☐Felony
Charge: _____
Outcome: _____

5. Trauma History

Role in Abuse/Violence

Have any of these people abused you? *(Insert name in blank areas)* ☐Yes ☐No

Have you abused anyone? *(Insert name in blank areas)* ☐Yes ☐No

Indicate from view of client. If person abused client, indicate Perpetrator, if client abused person, indicate Victim. If both, check both.

Spouse: _____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Father: _____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Step-Father:_____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Mother: _____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Step-Mother:_____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Grandparent:_____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Sibling: _____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Other/Non-family:_____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator
Stranger: _____	☐Emotionally	☐Physically	☐Sexually	☐Victim	☐Perpetrator

Have you ever witnessed domestic violence? ☐Yes ☐No

Have you ever experienced any type of psychological trauma in your life? ☐Yes ☐No
(i.e., Crime Related Events, General Disaster, Emotional Trauma, Physical or Sexual Experiences)

If yes, explain: _____
_____
_____
_____
_____

Present Psychosocial Stressors *(Check those that apply and comment as needed.)*

☐Recent Death ☐Divorce ☐Separation from a significant relationship
Comments: _____

☐Emotionally unable by past history to remain separated from a destructive relationship *(i.e., living with chemical abuser, physical/emotional/sexual abuser)*.
Comments: _____

☐Involves self in relationships with personality-disorder individuals
Comments: _____

☐Experiences anxiety, boundary difficulties, and separation issues in intimate relationships
Comments: _____

☐Assumes responsibility for meeting others needs to the exclusion of their own
Comments: _____

☐Other
Comments: _____

6. Family History

Marital/Significant Other Relationship History

How long have you been in current marital status? ____ Years ____ Months Number of times married: _____

Significant Other's Name: _____ Phone: _____
☐Same Address Address (if different): _____
City: _____ State: _____ Zip: _____

Family Relationships

Structure of family you live with? ☐Biological ☐Adoptive ☐Foster ☐Alone ☐Other: _____
☐Both parents living ☐Father deceased ☐Mother deceased ☐Parents married to each other
☐Parents separated ☐Parents never married ☐Parents divorced ☐Parents currently living together
☐Father remarried ☐Mother remarried ☐Mother unknown ☐Father unknown

While growing up, have/did you live under the care of anyone other than your parents? ☐Yes ☐No
If yes, with whom? _____ How long? _____
Address: _____ City: _____ State: _____ Zip: _____

Living Situation

Current Persons in the Home

Last Name	First Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

Current Living Situation *(Check only one)*
☐Residential Care Facility/Group Home ☐Permanent Housing ☐Temporary (Hotel, Friend, Family)
☐Residential Care Facility/Group Home ☐Transitional Housing (Half-way, Independent Living)

Homeless: ☐Homeless – Shelter ☐Homeless – Street

Usual Living Arrangement (past 3 years) *(Check one only)*

☐Sexual partner and children ☐Sexual partner only ☐Children alone ☐Parents ☐Family ☐Friends
☐Alone ☐Controlled environment ☐No stable arrangement

Are you satisfied with these arrangements? ☐Yes ☐Indifferent ☐No

Military

Military Service: ☐None ☐Active ☐Reserve ☐Discharged ☐Retired

Which branch of service: ☐Army ☐Navy ☐Air Force ☐Marines ☐Coast Guard ☐National Guard ☐Merchant Marine

Type of discharge: ☐Honorable ☐Medical ☐Dishonorable ☐Court Marshal

Relatives with military service: ☐Spouse ☐Mother ☐Father ☐Grandparent ☐Sibling ☐other: _____

7. Social History

Income

Source of Income *(Check all that apply)*

☐Employment ☐Spouse's Employment ☐ (Grand)Parents Employment
☐Mother's Employment ☐Father's Employment ☐Children's Employment
☐Title XIX/Medicaid/TANF ☐Title XX/Child Care Assistance ☐ Disability/SSDI
☐Pension/Social Security ☐Child Support ☐Alimony
☐SSI ☐Food Stamps ☐Section 8/Housing Assistance
☐Worker's Compensation ☐Illegal ☐Unemployment
☐Other: _____

Total Annual/Yearly Amount: $_____

Number of people who contribute to or must live on the total annual income: (1-15) _____

Are you able to pay monthly bills and meet budgeting and money needs? ☐Yes ☐No

Caregiver/Client Resources, Issues, or Concerns about Meeting Basic Needs *(food, shelter, health, transportation, etc.)*

Do you have a valid driver's license *(not suspended/revoked)*? ☐Yes ☐No

Do you have an automobile available for use *(does not require ownership, only availability)*? ☐Yes ☐No

Are you able to care for your basic needs such as food preparation and meal planning, obtaining clothing, completing chores, personal care, and life skills? ☐Yes ☐No

Are you able to meet your needs for medical, dental, and mental health, including abuse/neglect, violence or domestic violence, and/or substance abuse concerns? ☐Yes ☐No

Are you able to meet your legal demands? ☐Yes ☐No

Do you have the resources to meet your recovery needs and/or recovery environment? ☐Yes ☐No

Are the resources available to your family adequate in meeting the family's basic needs? ☐Yes ☐No

If no on any of the above, describe the limitations: _____
_____

Language

Primary Language:
☐English ☐Spanish ☐French ☐Cherokee ☐Creek
☐Choctaw ☐Chickasaw ☐Kiowa ☐Cantonese ☐Mandarin
☐Farsi ☐Japanese ☐Other: _____

Secondary Language:
☐English ☐Spanish ☐French ☐Cherokee ☐Creek
☐Choctaw ☐Chickasaw ☐Kiowa ☐Cantonese ☐Mandarin
☐Farsi ☐Japanese ☐Other: _____

Speak English well? ☐Yes ☐No Read English well? ☐Yes ☐No Write English well? ☐Yes ☐No
If no, please describe: _____

Religion/Spiritual Orientation

Which religion do you identify with? _____

Do you currently attend church or religious services? ☐Yes ☐No

If yes, what denomination? _____

Have your behaviors impacted your views of spirituality? ☐Yes ☐No

Do you see a healer? ☐Yes ☐No

What meaning does God, Spirituality, or a Higher Power play in your life? *(in client's words)*

_____

_____

_____

Recreational/Leisure

If girlfriend/boyfriend is considered as family, then refer to them as family throughout this section.

With whom do you spend most of your free time? ☐Family ☐Friends ☐Alone

Are you satisfied with spending your free time this way? ☐Yes ☐No

How many close friends do you have? (Exclude family members. *Reciprocal/mutually supportive relationships*. _____

What do you do or have you done for fun or enjoyment? _____

_____

_____

_____

8. Educational History

What is the highest grade in school you have satisfactorily completed? _____

Did you repeat any grades? ☐Yes ☐No If yes, which grades? _____

Why? _____

Name of school last attended: _____ School district: _____

How many months of Training or Technical education have you satisfactorily completed? _____ months

Highest Grade Level:

☐Drop-Out Grade:_____ ☐Some College
☐High School Diploma ☐Bachelors
☐G.E.D. ☐Masters
☐ Vo-Tech ☐ Doctorate

Learning Ability/Intellectual Functioning

Would you describe yourself as a: ☐slow learner ☐average learner ☐quick learner

Vocational History

Employment Status: ☐Full-time ☐Part-time ☐Unemployed ☐Not in Labor Force ☐Homemaker ☐Student ☐Retired ☐Disabled ☐Inmate ☐Erratic Job History ☐Job Affected by Usage/Behavior ☐Other: _____ ☐Threat of Job Loss ☐Workers Comp

Employment Type: ☐Competitive ☐Supportive ☐Volunteer ☐None ☐Transitional ☐Sheltered Workshop

Have you worked at any job outside the home? ☐Yes ☐No
If so, what type of work was it? _____ For how long? _____

Last time you worked? _____ What type? _____

Do you have any special job skills or training? ☐Yes ☐No
What type? _____

What type of work do you intend to do or have you done as a career? _____

II. Client Rights, Agency Code of Ethics to Customers, Client Grievance Procedures, License Disclosure
Synopsis of Client Rights (per OAC 450:15-3-27), Code of Ethics to Customers, Client Grievance Procedures, and License Disclosure have been provided to the client at the time of intake.

III. Confidentiality and Exceptions to Confidentiality including Data Collection and Research
Great Plains Youth & Family Services, Inc. (GPYFS) shall meet the requirements of all applicable state and federal laws, rules, and regulations. Public law 99-401 amends the federal confidentiality laws to require that cases involving suspected, actual, or imminent harm to children must be reported to child protection agencies and therefore are not covered by confidentiality requirements. This applies only to initial reports of child abuse or neglect and not to requests for additional information or records. Court orders are still required before records may be used to initiate or substantiate any criminal charge or to conduct any investigation of a patient. Client records are considered confidential and will not be released to other individuals or agencies without your expressed written consent, except upon receipt of a legitimate subpoena, in the event of a valid medical emergency, to meet the requirements of state law that child/elderly abuse must be reported, or in the event you present a danger to yourself or to others.

Oklahoma State Law (43A O.S. § 1-109) provides that a consumer of a physician, psychotherapist, mental health facility, a drug or alcohol abuse treatment facility or service, or other agency for the purpose of mental health or drug or alcohol abuse care and treatment shall be entitled to personal access to his or her mental health or drug or alcohol abuse treatment information, except the following:

1. Information contained in notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session, and that is separated from the rest of the patient's medical record;
2. Information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding;
3. Information that is otherwise privileged or prohibited from disclosure by law;
4. Information the person in charge of the care and treatment of the patient determines to be reasonably likely to endanger the life or physical safety of the patient or another person;
5. Information created or obtained as part of research that includes treatment; provided, the patient consented to the temporary suspension of access while the research is ongoing. The patient's right of access shall resume upon completion of the research;
6. Information requested by an inmate that a correctional institution has determined may jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other person; and
7. Information obtained under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Oklahoma State Law (43A O.S. § 1-109) provides that all mental health and drug or alcohol abuse treatment information, whether or not recorded, and all communications between a physician or licensed mental health professional as defined in Section 1-103 of this

title, or a licensed alcohol and drug counselor as defined in Section 1871 of Title 59 of the Oklahoma Statutes, and a consumer are both privileged and confidential. In addition, the identity of all persons who have received or are receiving mental health or drug or alcohol abuse treatment services shall be considered confidential and privileged.

Federal regulations (42 CFR Part 2) prohibit making any further disclosure of information unless disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol/drug abuse patient.

Since part of the cost of your treatment may be paid by federal, state, or local sources, those sources have the right to review client files to verify that these services have been delivered appropriately. This review is done for accounting or evaluative purposes only, with no files or clinical information removed from this agency. Others having review access to your file are agency staff, consultants, and accountants.

As a result of participation, occasional guest speakers, outings, or field trips may be scheduled. Under these circumstances confidentiality is limited to the extent that community resource workers recognize the client as a participant in the program of GPYFS.

GPYFS collects data on all clients who are served by our program. As a component of its contracts with the State of Oklahoma, GPYFS must enter client names, information, and statistical data into online databases. This system is specifically designed to protect the safety and confidentiality of client data so that no unauthorized participating agency can gain access to confidential client information regarding services that clients and their families receive from or through GPYFS.
GPYFS routinely participates in a variety of research and evaluation projects by providing anonymous data we collect about the clients we serve. At no time will clients be identified by name or implication as part of such anonymous reporting of data.

IV. Consent for Treatment

Consent extended to Great Plains Youth & Family Services, Inc. (Agency).
I, We (Parent, legal guardian if applicable) authorize the Agency to administer treatment to me/my child and to continue such treatment as deemed necessary.

I/We hereby authorize medical, psychiatric, psychological, diagnosis, or treatment by any physician, therapist, and/or qualified mental health provider authorized by the Agency. I/We understand that this consent is given before any specific diagnosis or treatment is required, but is given to authorize the Agency to exercise its judgment in providing treatment.

I/We agree to be actively involved in the treatment plan as prescribed by the Agency treatment team while I/We receive treatment. I/We understand that included in this treatment plan would be my/our involvement in regular family, individual, group therapy, and case management sessions.

No guarantees have been given by anyone as to the results that may be obtained.

I/We consent to being contacted after discharge for the purpose of obtaining information in efforts to improve the quality of care (e.g., client satisfaction surveys, etc.). At any time, I/We have the right to decline contact after discharge. Treatment does not depend on my/our agreement to participate in contact after discharge.

THIS CONSENT SHALL REMAIN IN EFFECT COMMENCING ON THE DATE OF ADMISSION UNTIL THE CLIENT HAS BEEN DISCHARGED; AND FOR THE PURPOSES OF FOLLOW UP, UNLESS REVOKED IN WRITING AND DELIVERED TO THE AGENCY.

V. Acknowledgements and Signatures

- I/We have provided the information in Section I (Initial Intake Information) and, upon review, find it to be accurate to the best of my/our knowledge.
- I/We have been provided the information in Section II (Synopsis of Client Rights (per OAC 450:15-3-27), Agency Code of Ethics, Client Grievance, Licensure Disclosure, Treatment Advocate) and offered a copy of the full Mental Health and Drug or Alcohol Abuse Services Bill of Rights (OAC 450:15-3-6 through 450:15-3-25) indicating my/our rights concerning client rights. If I could not understand the language in the synopsis, I was provided the option of an oral explanation of the synopsis in a language I can understand and given a choice of receiving the full-length version and explanation of the Mental Health and Drug or Alcohol Abuse Services Bill of Rights. By signing below, I am verifying that I/we understand my/our client rights.
- I/We have received, read or had it read to me/us, and have had to opportunity to ask questions regarding, a copy of the Agency Code of Ethics to Customers Form. By signing below, I am verifying that I/we understand the Agency Code of Ethics.

Client: Last Name: _____ First: _____ MI: _____

- I/We have received, read or had it read to me/us, and have had to opportunity to ask questions regarding the agency grievance procedures, and if requested I/We received a copy of the Client Grievance Form. By signing below, I am verifying that I/we understand the grievance procedure.
- I/We have received, read, and understand the statement in Section III (Confidentiality and Exceptions to Confidentiality including Data Collection and Research, Notice of Privacy Practices). By signing below, I am verifying that I/we have received and understand the Agency Confidentiality and Exceptions to Confidentiality including Data Collection and Research. By signing below, I am verifying that I/we have received and understand the Agency Notice of Privacy Practices.
- I/We have read Section III (Consent for Treatment), understand all of its contents and sign my/our name(s) freely, voluntarily and without coercion.
- I/We understand that services are provided by GPYFS regardless of ability to pay. If able, I/We agree to pay when services are rendered and charged.
- I/We have been made aware that HIV/STD/AIDS and other communicable disease education, counseling, and testing will be made available to me, my spouse, and significant other(s), if desired. During orientation, I have been made aware of the process by which HIV/STD/AIDS testing and counseling services may obtain.
- I/We have received an orientation packet including Synopsis of Client Rights, Agency Code of Ethics, Grievance Procedures, HIPAA information and Exceptions to Confidentiality, Program Rules and Expectations (if applicable), Program Description (if applicable), Emergency Contact Numbers, Individual Rights and Responsibilities (if applicable). A GPYFS employee explained the orientation materials to me/us and I/we fully understand these materials. **_____ Initial**
- I/We agree to give 24 hours notice of cancellation if not participating in planned services and understand that if I/We do not show up for planned services, the treatment plan may be reviewed to determine the appropriateness of continued treatment or, possibly, discharge. **_____ Initial**
- I/We understand that GPYFS shall be notified of any changes to my/our phone number or mailing address within 2 business days. **_____ Initial**
- I/We have been provided notice of license disclosure for all Licensed Professional Counselors (59 O.S. § 1916.1) and Licensed Behavioral Practitioners (59 O.S. § 1944) that may be involved in my/our treatment. Oklahoma regulations require that you be informed of your counselors' professional training, orientation/techniques, fees, and credentials. Some counselors may be working towards licensure as a Professional Counselor or Behavioral Practitioner under the auspices of the Oklahoma State Department of Health. He/She is in the process of accruing 3000 hours of supervised experience, which are required for licensure. Until licensed, he/she has a supervising licensee providing supervision. Your counselor will be happy to discuss with you and/or furnish you with printed materials concerning the licensing process. You may contact (without giving your name), the Professional Counselor Licensing Division provided in the attachments. The Professional Counselor Licensing website is www.health.ok.gov/program/lpc. My counselors have satisfactorily supplied me the information regarding his/her practice, licensure, and professional development.
- If the client is under the age of fourteen (14), I/we certify that I/we have legal standing to authorize these professional psychological services; or, that I have legal custody and/or other required legal standing to request and authorize professional psychological services for this child.

_____ _____

Signature of Client (14 or older) or Representative — Date

IF REPRESENTATIVE signature, please indicate relationship to client:

_____ _____

Signature of Parent/Guardian (if applicable) — Date

_____ _____ _____

Signature of Staff/Witness — Title — Date

Client: Last Name: _____ First: _____ MI: _____