GREAT PLAINS YOUTH & FAMILY SERVICES, INC.

901 S. BROADWAY
HOBART, OKLAHOMA 73651

580.726.3383
FAX: 580.726.3384

WWW.GPYFS.ORG

CHILD INTAKE ASSESSMENT (Age 4-11)

Date:_____

1. Identifying Information

Last Name: _____ First Name: _____ MI: _____

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

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

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

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 for the person served?_____
_____
_____
_____
_____
_____
_____

2. Health Care

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

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 NO, explain: _____
_____
_____
_____

Prenatal/Mother's condition while pregnant: ☐Normal ☐Unknown
Explain: _____
_____

Perinatal (Condition at birth) ☐Normal/Full term ☐Premature _____ weeks ☐Unknown

Complications: _____
_____

Handicaps/Disabilities/Limitations/Challenges

Is person served 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

Adjustment to disabilities or disorders by person served: _____
_____

3. Mental Health History

Treatment

How many times has the person served been treated for any psychological, 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

Does person served have a history of other at-risk behaviors? ☐Yes ☐No

If yes, check all that apply: ☐Eating Disorder ☐Fire Starting ☐Exercise ☐Self-mutilation
☐Any Other Risk-Taking Behaviors: _____

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

_____

_____

Family History of Alcohol or Drug Use

Have any family members of the person being served 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

5. Trauma History

Role in Abuse/Violence

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

Has person served 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

Has the person served ever witnessed domestic violence? ☐Yes ☐No

Has the person served ever experienced any type of trauma in their life? ☐Yes ☐No
(i.e., Crime Related Events, General Disaster, Emotional Trauma, Physical or Sexual Experiences)

If yes, explain: _____
_____
_____
_____
_____

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the person served. Mark NO if it didn't happen to the person served.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐Yes ☐No
2. Serious accident or injury like a car/bike crash, dog bite, or sports injury. ☐Yes ☐No
3. Robbed by threat, force, or weapon. ☐Yes ☐No
4. Slapped, punched, or beat up by someone in his/her family. ☐Yes ☐No
5. Slapped, punched, or beat up by someone not in his/her family. ☐Yes ☐No
6. Seeing someone in the family of the person served get slapped, punched, or beat up. ☐Yes ☐No
7. Seeing someone in the community get slapped, punched, or beat up. ☐Yes ☐No
8. Someone older touching the private parts of the person served when his/her shouldn't. ☐Yes ☐No
9. Someone forcing or pressuring sex, or when the person served couldn't say no. ☐Yes ☐No
10. Someone close to the person served dying suddenly or violently. ☐Yes ☐No
11. Attacked, stabbed, shot at, or hurt badly. ☐Yes ☐No
12. Seeing someone attacked, stabbed, shot at, hurt badly, or killed. ☐Yes ☐No
13. Stressful or scary medical procedure. ☐Yes ☐No
14. Being around war. ☐Yes ☐No
15. Other stressful or scary event? ☐Yes ☐No
    Describe: _____

Which one is bothering the person served the most now? _____

If person served marked YES to any stressful or scary events, please answer the next questions about the one that is bothering the person served the most now.

Circle 0, 1, 2, or 3 for how often the following things have bothered person served in the last two weeks:

	0=Never	**1=Once in a while**	**2=Half of the time**	**3=Almost always**
1. Upsetting thoughts or pictures about what happened that pop into the person served head	0	1	2	3
2. Bad dreams reminding person served of what happened	0	1	2	3
3. Feeling as if what happened is happening all over again	0	1	2	3
4. Feeling very upset when person served is reminded of what happened	0	1	2	3
5. Strong feelings in the body of the person served when the person served is reminded of what happened (sweating, heart beating fast, upset stomach)	0	1	2	3
6. Trying not to think about or talk about what happened or to not have feelings about it	0	1	2	3
7. Staying away from people, places, things, or situations that remind person served of what happened	0	1	2	3
8. Not being able to remember part of what happened	0	1	2	3
9. Negative thoughts about the person served or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe	0	1	2	3
10. Blaming the person served for what happened, or blaming someone else when it isn't his/her fault	0	1	2	3
11. Bad feelings (afraid, angry , guilty, ashamed) a lot of the time	0	1	2	3
12. Not wanting to do things person served used to do	0	1	2	3
13. Not feeling close to people	0	1	2	3
14. Not being able to have good or happy feelings	0	1	2	3
15. Feeling mad or having fits of anger and taking it out on others	0	1	2	3
16. Doing unsafe things	0	1	2	3
17. Being overly careful or on guard (checking to see who is around the person served)	0	1	2	3
18. Being jumpy	0	1	2	3
19. Problems paying attention	0	1	2	3
20. Trouble falling or staying asleep	0	1	2	3

Please mark YES or NO if the problems person served marked interfered with:

1. Getting along with others	☐Yes	☐No	4. Family relationships	☐Yes	☐No
2. Hobbies/Fun	☐Yes	☐No	5. General happiness	☐Yes	☐No
3. School or work	☐Yes	☐No			

6. Family History

Family Relationships (*Check all that apply)*

Structure of family person served lives 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, has/did the person served lived under the care of anyone other than their parents? ☐Yes ☐No
If yes, with whom? _____ How long? _____
Address: _____ City: _____ State: _____ Zip: _____

Who is (or was) the primary disciplinarian in the home? _____
Is/was it deserved and fair? ☐Yes ☐No
If not, why? _____
_____
How were person served punished? _____
_____

Siblings: (List last, first, middle initial, age of each, and if he/she live in the home with person served)

Last Name	First Name	MI	Age	In Home?
1.				Y N
2.				Y N
3.				Y N
4.				Y N
5.				Y N
6.				Y N

Other Persons Living in the Home

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

Living Situation

Current Living Situation *(Check only one*): ☐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 person served satisfied with these arrangements? ☐Yes ☐No ☐Indifferent

Military

Relatives with military service: ☐Spouse ☐Mother ☐Father ☐Grandparent ☐Sibling ☐Other: _____
Which branch of service: ☐Army ☐Navy ☐Air Force ☐Marines ☐Coast Guard ☐National Guard ☐Merchant Marine

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) _____

Is the person served 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.)*

Does the person served have a valid driver's license *(not suspended/revoked)*? ☐Yes ☐No

Does the person served have an automobile available for use *(does not require ownership, only availability)*? ☐Yes ☐No

Is person served able to care for his/her basic needs such as food preparation and meal planning, obtaining clothing, completing chores, personal care, and life skills? ☐Yes ☐No

Is person served able to meet his/her needs for medical, dental, and mental health, including abuse/neglect, violence or domestic violence, and/or substance abuse concerns? ☐Yes ☐No

Is the person served able to meet his/her legal demands? ☐Yes ☐No

Does the person served have the resources to meet their recovery needs and/or recovery environment? ☐Yes ☐No

Are the resources available to the family of the person served 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 does the person served identify with? _____

Does the person served currently attend church or religious services? ☐Yes ☐No

If yes, what denomination? _____

Have the behaviors of the person served impacted their views of spirituality? ☐Yes ☐No

Does the person served see a healer? ☐Yes ☐No

Recreational/Leisure

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

With whom does the person served spend most of his/her free time? ☐Family ☐Friends ☐Alone

Is person served satisfied with spending his/her free time this way? ☐Yes ☐No

How many close friends does the person served have*? (Exclude family members. Reciprocal/mutually supportive relationships.)* _____

What does person served do in his/her free time or has he/she done for fun or enjoyment? _____
_____
_____
_____

8. Educational History

Current Educational Functioning

Current school status: ☐Currently Attending ☐Suspended ☐Expelled ☐Truant
☐Online School ☐Homebound/Medical

What is the highest grade in school person served has satisfactorily completed? _____

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

Why? _____

Name of school last attended: _____ School district: _____

What subject did/does person served like in school?

☐Art	☐Computers/Technology		☐Debate
☐Drama	☐English	☐Music	☐Industrial Arts/Vo-Tech
☐Language	☐History	☐Science	☐Physical Education
☐Public Speaking	☐Mathematics	☐Shop	☐Social Studies

What subject did/does person served dislike in school?	☐Art	☐Computers/Technology		☐Debate
	☐Drama	☐English	☐Music	☐Industrial Arts/Vo-Tech
	☐Language	☐History	☐Science	☐Physical Education
	☐Public Speaking	☐Mathematics	☐Shop	☐Social Studies

Learning Ability/Intellectual Functioning

Would the person served describe him/herself self as a: ☐slow learner ☐average learner ☐quick learner

What is the current school performance (grades or GPA) of the person served? _____

Reading Literacy Level: _____ Writing Literacy Level: _____

Does the person served have a special education classification? ☐Reading &/or Math Lab ☐Learning Disabilities ☐Developmental Delayed ☐Other Health Impairment *(Physical Therapy, Occupational Therapy, or Speech Therapy)*

Is person served currently being served on an IEP? ☐Yes ☐No

In the past 90 days of the school year, how many days was the person served absent from school? _____

In the past 90 days of the school year, how many days was the person served suspended from school? _____

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, 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 their 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.
- 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: _____