Oasis Counseling for Women and Children
1900 14th Avenue South
Birmingham, AL 35205
Tel: 205-933-0338 Fax: 205-933-0343

INTAKE INFORMATION—CHILD/ADOLESCENT

Child's Name:_____ Date:_____

Child's Birthdate:_____ Race:_____ Gender: M F

Child lives with:_____

Address:_____

City:_____ County:_____

State:_____ Zip:_____ OK to receive mail/messages?_____

Primary phone:_____ Home Cell Work

Secondary phone:_____ Home Cell Work

Referred by_____

PARENT/GUARDIAN INFORMATION

Who holds legal custody of the child?_____

Child's parents are: Never married Married Separated Divorced
Deceased: Mother Father

If child's parents are divorced, what is the type of custody?_____

A copy of the custody order must be provided to Oasis.
If joint custody, both parents must consent to counseling

Mother's Name:_____ Phone:_____

Address: _____

Occupation/Employer_____

Father's Name_____ Phone:_____

Address: _____

Occupation/Employer_____

Legal Guardian's name:_____ Phone:_____

Address:_____

DHR Social Worker's Name:_____ Phone_____

EMERGENCY CONTACT (other than parent/guardian)

Name:_____Relationship:_____

Address:_____

Primary phone:_____ Secondary phone:_____

Client Name_____

PARENT/GUARDIAN FINANCIAL INFORMATION

Gross **Annual** Family Income:_____ Number of IRS dependents: _____

Health Insurance Provider:_____

Policy number:_____

If you must CANCEL or reschedule an appointment, please **call by 12 noon the day BEFORE the appointment date.** You will be charged one-half of your regular fee if an appointment is cancelled **after 12 NOON the day BEFORE your appointment**. If you fail to come for your scheduled appointment **without calling**, you will be charged your full fee. **Please Initial**_____

Payment or co-payment is expected at the time of service. If no payment has been made for more than two sessions, we will not schedule another session until some payment has been made. **Please Initial**_____

I HAVE REPORTED ALL INCOME/ASSESTS FOR MY WHOLE HOUSEHOLD, AS NOTED ABOVE.
I understand that I must notify the Business Office in the event that this information changes.
I understand that I am responsible for all charges incurred while I am a client at Oasis Counseling, unless I have indicated another responsible party to the Oasis Office Manager.

I understand that my per-session fee will be: $_____ (To be completed by Oasis)
I will notify Oasis of any changes in my financial status.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

MEDICAL/CLINICAL/SOCIAL INFORMATION

Briefly state why you are seeking counseling for your child at this time:_____

_____

_____

_____

When did this problem begin?_____

Previous Counseling: Y N Where and when?_____

Medical Problems, if any:_____

Current Medication: Reason for taking:

_____ _____

_____ _____

_____ _____

Primary Physician:_____ Phone:_____

Was there anything out of the ordinary about child's early development? Y N

Please explain_____

_____

Current School:_____ Grade:_____

Performance in school: Good Average Poor

Briefly describe any school related problems:_____

_____

Hobbies or social activities:_____

Religious affiliation, if any:_____

Please list all siblings:

Name	Age	Where they live (if not with child)

Client Name_____

Please list all others living in the home and indicate their relationship to the child:

Name	Age	Relationship to Child

Is there anything else that you want to share about child's family?_____

_____

Please check all events that have happened to your child within the past 12 months:

[ ] Death of parent
[ ] Death of close family member
[ ] Death of close friend
[ ] Marital conflict in parents
[ ] Witnessing domestic violence
[ ] Parents separated
[ ] Parents divorced
[ ] Parent incarcerated
[ ] Personal injury or illness
[ ] Injury or illness in close family member
[ ] Change in family's financial status
[ ] Pregnancy
[ ] Birth of child
[ ] Gain of new family member
[ ] Change in residence
[ ] Change in school
[ ] Significant conflict at school
[ ] Loss of job (parent or child)
[ ] Legal problems (parent or child)
[ ] Physical assault
[ ] Sexual assault
[ ] Natural disaster (flood, tornado)
[ ] Other Stressors_____

_____

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Client Name: _____

Counselor/Client Agreement

The mission of Oasis Counseling for Women and Children (Oasis) is to help women and children heal, grow, and overcome difficult life challenges by providing affordable mental health counseling and innovative educational programs in a respectful and nurturing environment.

Welcome to Oasis. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before your first session. We can discuss any questions you have about the procedures at that time. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The Counseling Process: Counseling is a cooperative learning process through which you will grow into taking enhanced control over your life and become more self-motivated and empowered. This process requires a commitment for you to explore the problems that brought you to counseling. At times, counseling may stir up feelings of discomfort and a realization that a loss or previously unresolved issue may contribute to your current situation. Counseling can also result in humor and fun, relief, new insights, and behavior change. The greater the investment you make in counseling by expressing your feelings and opinions about the process, the more successful this endeavor will be for you. Sometimes outside "homework" is helpful such as reading, journal writing, exercising, or simply taking better care of yourself.

Confidentiality: Under the code of ethics for Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, and Psychologists, PHI, particularly information shared in the counseling session, is strictly confidential and will not be disclosed without your written authorization except in these situations:

1) When there is clear and immediate danger to you, other individuals, or society, we are required to intervene. If we believe you pose a life-threatening risk to yourself or to others, we may need to notify responsible individuals for your protection. In this case, we may call your emergency contact person, a friend or relative, or summon the police to take you to a hospital for psychiatric evaluation or observation.
2) Child abuse reporting laws in the State of Alabama require counselors to report suspected cases of child abuse to the Department of Human Resources. Child abuse and neglect may include physical, emotional or sexual abuse of children and the abandonment of children.
3) If we know that an elderly or disabled adult has been abused, neglected, and/or exploited, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
4) If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, we will not disclose information without your (or your legal representative's) written authorization, a subpoena, or a court order.
5) In order to receive payment from insurance companies or other agencies, we may be asked to release details about your treatment with us. When disclosing information we will make reasonable efforts to limit the information to the minimum necessary to accomplish the intended purpose of the disclosure.

6) At times, we may consult with a professional on our staff if we feel it is needed to offer the best possible service for you. During a consultation we make every effort to avoid revealing the identity of the client.
7) You should be aware that we employ administrative staff and occasionally need to share information with them related to scheduling, billing, and quality assurance. All of our staff are bound by the same rules of confidentiality and have been given training about protecting your privacy.
8) Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their treatment records unless we decide that such access is likely to be harmful to the child, or we agree otherwise. The therapeutic relationship with children is to be respected. Children need to know that they can trust their counselor and feel safe and secure in their counseling sessions. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is often our policy to request an agreement from the parents that they consent to give up their access to their child's records. If they agree, we will provide them with general information regarding the child's treatment and attendance at scheduled sessions. We will also provide parents with a summary of the child's treatment when complete. Any other communication will require the child's authorization unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she might have.
9) If a government agency is requesting information for health oversight activities, we are required to provide it.
10) If a client files a worker's compensation claim, we may disclose information relevant to that claim to the client's employer or insurer.
11) We reserve the right to use the information you share to evaluate our services and conduct research. Anonymity will be maintained through the use of code; no identifying information will be used.

For clients of Oasis who are covered by Alabama Medicaid: Dr. Heather Austin is an Alabama licensed psychologist who provides regular supervision services to Oasis counselors who serve clients with Medicaid insurance. Dr. Austin's supervision services are required to meet Alabama Medicaid billing guidelines. In order to comply with those guidelines, please understand that your Protected Health Information (PHI) will be shared with Dr. Austin as a part of your counselor's supervision. Additionally, Medicaid requires that information about your treatment be shared with your referring physician. If you have any concerns related to your care or the supervision process, you may speak with your counselor. You also may feel free to contact Dr. Austin by calling (205) 933-0338.

By initialing this section of the Informed Consent, you are agreeing to the disclosure of your PHI to your referring physician and to Dr. Austin. Initials_____

Appointments: Appointments are scheduled on the hour and last **fifty minutes**. Counseling is a time-sensitive activity and your appointment is reserved specifically for you. If you must cancel or reschedule an appointment, please call **24 hours** before the appointment time. **Cancellations made AFTER 12 noon the day BEFORE will be charged one-half your regular fee. If you fail to show for your scheduled time without calling, you will be charged your regular fee at your next session.** If there is a consistent pattern of failed or cancelled appointments, you will need to speak with your counselor before any further appointments can be scheduled. You may be referred to another agency as a result of appointment non-compliance.

Length and Termination of Counseling Sessions: The number of counseling sessions may vary depending on the type and severity of problems. Your counselor will take into account individual factors and discuss a time frame that meets your needs. Because of the importance of the therapeutic relationship between client and counselor, we encourage you to talk to your counselor if you are considering leaving counseling. The counseling process involves a growth experience. Therefore, terminating the relationship is part of that growth experience. Oasis employs play therapists to work with children. It is imperative that play therapy sessions are consistent with the time and number of sessions agreed on by the therapist and the parent. Please discuss this with the play therapist in the preliminary interview if you feel you cannot make this commitment..

Fees and Payment: Your fee is based on your income and number of dependents. We ask that you provide accurate information concerning your income and inform us if there are any changes while receiving counseling at Oasis. Payment is expected at the time of treatment. If you have concerns regarding your payment, this may be discussed with your counselor and the Office Manager.

Business Hours: Our business hours are from 8:30 a.m. to 5:00 p.m. Monday through Friday. Early morning appointments may be arranged at your counselor's discretion. Oasis has voice mail after hours. If you leave a message, we will return your call as soon as possible. However, if you feel that you need immediate assistance after-hours, you should contact the Crisis Center at 323-7777, contact your primary care physician, or go to the nearest emergency room.

Procedures Regarding Legal Proceedings: If you are involved in a legal matter, your attorney may request copies of your records or that your counselor testify in court. There are additional charges for provision of records and/or time needed by the counselor to prepare for court and/or testify. These need to be discussed with your counselor if such services are requested. For any release of records for court proceedings, a subpoena is required.

Client's Rights: HIPAA provides you with new or expanded rights with regard to your Clinical Record and disclosure of Protected Health Information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a copy of this Agreement, the attached Notice Form, and our privacy policies and procedures.

Client Grievance: To support the mission of Oasis, the following Client Grievance Procedure has been developed:

1) In the event a client experiences a problem or has a concern related to their treatment at Oasis, the client should first attempt to resolve the problem with the counselor.
2) If no satisfactory solution is achieved, or if the client is uncomfortable discussing the situation with the counselor, the client may bring the matter to the Clinical Director. The Clinical Director will keep a written record of the problem and the subsequent resolution.
3) If again, no satisfactory solution is achieved, or if the situation involves the Clinical Director, the client may bring the matter to the Executive Director. The Executive Director will keep a written record of the problem and the subsequent resolution.
4) If a problem or concern involves administrative staff, these issues should be reported in writing or by email by the counselor to the Executive Director.

IF YOU HAVE ANY QUESTIONS ABOUT THIS AGREEMENT, PLEASE ASK YOUR COUNSELOR. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

WELCOME TO OASIS. WE HOPE YOU HAVE A MEANINGFUL AND SUCCESSFUL COUNSELING EXPERIENCE.

_____	__/__/__	_____
Client/Parent or Guardian Signature	Date	Printed Name/Relationship to client
_____	__/__/__	_____
Client/Parent or Guardian Signature	Date	Printed Name/Relationship to client
_____	__/__/__	
Counselor Signature	Date	

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Client Name: _____ **Date:** _____

WHO-Five Well-being Index (WHO-Five)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	I have felt cheerful and in good spirits	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	I have felt calm and relaxed	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	I have felt active and vigorous	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	I woke up feeling fresh and rested	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	My daily life has been filled with things that interest me	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Total Score: _____

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Client Name: _____ **Date:** _____

PATIENT QUESTIONNAIRE – PRIME-MD

1. **Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems?**

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. **If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Score: _____

United Way
United Way
of Central Alabama, Inc.

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Telephone 205 933 · 0338 or Fax 205 933 · 0343
www.oasiscounseling.org

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Client Name: _____ Date: _____

ANXIETY SCREEN

	Yes	No
1. Most days I feel very nervous	☐	☐
2. Most days I worry about lots of things.	☐	☐
3. Most days I cannot stop worrying.	☐	☐
4. Most days my worry is hard to control.	☐	☐
5. I feel restless, keyed up or on edge.	☐	☐
6. I get tired easily.	☐	☐
7. I have trouble concentrating.	☐	☐
8. I am easily annoyed or irritated.	☐	☐
9. My muscles are tense and tight.	☐	☐
10. I have trouble sleeping.	☐	☐
11. Did the things you noted above affect your daily life (home life, or work, or leisure) or cause you a lot of distress?	☐	☐
12. Were the things you noted above bad enough that you thought about getting help for them?	☐	☐

Total Score _____

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