

Oasis Counseling for Women and Children

1900 14th Avenue South

Birmingham, AL 35205

Tel: 205-933-0338

Fax: 205-933-0343

INTAKE INFORMATION--ADULT

Today's Date: _____

Name _____ DOB _____ SSN _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

County _____ Work Phone _____

Marital Status _____ Race _____ OK to receive Mail/Messages? _____

Referred by _____ Referring Individual _____

Emergency Contact _____ Emerg. Phone 1 _____

Relationship _____ Emerg. Phone 2 _____

Address _____ City _____ State _____ Zip _____

FINANCIAL INFORMATION

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

Health Insurance Carrier: _____ 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** _____

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/ASSETS 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.

CLIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

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Name: _____

Date _____

GENERAL INFORMATION

Primary Physician _____

Medical Problems _____

Current Medications _____

Education Level _____

Current Employer _____ Job Title _____

FAMILY INFORMATION

Name of significant partner or spouse _____

Names and ages of children/step-children _____

Who lives in the household with you? _____

Parents: Mother living deceased Parents Married Divorced
 Father living deceased Never married

Names and ages of brothers and sisters: _____

Leisure and recreation activities/hobbies: _____

Religious affiliation _____

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Name: _____

Date _____

Any legal problems or history of arrests? No Yes Explain _____

Do you use alcohol? No Yes How much/How often: _____

Do you use drugs? No Yes What/How often: _____

Substance Abuse Treatment History: Dates: _____

Location: _____

Please check all events that have occurred within the past 12 months:

- | | |
|---|--|
| <input type="checkbox"/> Significant marital conflicts | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Birth of child |
| <input type="checkbox"/> Spouse with emotional difficulties | <input type="checkbox"/> Gain of new family member |
| <input type="checkbox"/> Death of spouse | <input type="checkbox"/> Child leaving home |
| <input type="checkbox"/> Death of close family member | <input type="checkbox"/> Significant conflicts at work |
| <input type="checkbox"/> Death of close friend | <input type="checkbox"/> Losing job |
| <input type="checkbox"/> Personal injury or illness | <input type="checkbox"/> Change in job |
| <input type="checkbox"/> Change in financial status | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Change in residence | <input type="checkbox"/> Natural Disaster (flood, tornado) |
| <input type="checkbox"/> Physical assault | |
| <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Other stressors _____ |

Please add any additional information that you wish: _____

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	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2	I have felt calm and relaxed	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3	I have felt active and vigorous	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4	I woke up feeling fresh and rested	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
5	My daily life has been filled with things that interest me	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

Total Score _____



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Client Name: _____

Date: _____

PATIENT QUESTIONNAIRE – PRIME-MD

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

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

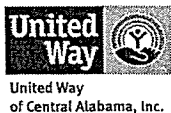
Not difficult at all

Somewhat Difficult

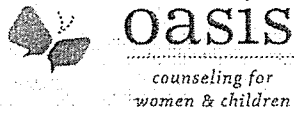
Very Difficult

Extremely Difficult

Total Score: _____



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www.oasiscounseling.org

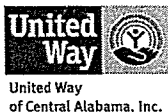


Client Name: _____ Date: _____

ANXIETY SCREEN

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

Total Score _____



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