Client Information Form

Thank you for taking some time to fill out the following confidential information. This information will help us do a more effective assessment. Feel free to write information you think is important, even if it is not specifically requested.

Personal and contact information

Date: ___________________

Legal Name: ________________________________ Date of Birth: ________________

Name You Use (if different): _____________________ Gender:_____________________

Race/Ethnicity:______________________ Sexuality: ___________________

Address: ____

Phone number: ________________________________

OK to text: ___Yes ___No OK to leave voicemail: ____Yes ____No

Email address:__________________________________

Preferred method of communication: ___Phone ___Text ___Email ___Other (what?)_____________

Are you involved with the court system or have you been in the past? If so, how?

____

____

Current school and grade (if attending):______________________________

Attending regularly: ____Yes ____No

Are you employed? ______________ If so, where: _____________________________________

Who lives in your home?

First Name	Last Name	DOB/Age	Relationship to client

Are there family members important to you who do not live with you?

First Name	Last Name	Relationship to client

Medical information

Primary care physician: _________________________________

Psychiatrist: _____________________________________

Are you currently seeing other professionals? Please list: ____________________________________

____

____

Current medications:

Medication Name	Dosage	Times Taken	When Prescribed

Do you have current medical conditions or allergies? Please list:

____

Have you had any significant medical issues in the past? Please list: ______________________________

____

Please indicate which, if any, of the following applies to you:

	Characteristic		Characteristic
☐	Anger outbursts / Agitation	☐	Increased aggression
☐	Anxiety/nervousness	☐	Irritable
☐	Abuse-sexual	☐	Issues with appetite
☐	Binge eating	☐	Loss of interest in pleasurable activities
☐	Blames others	☐	Low self-esteem
☐	Body image distortion	☐	Memory problems
☐	Change in friends	☐	Motivation problems
☐	Chest feels tight	☐	Nightmares
☐	Child abuse – physical	☐	Obsessions/compulsions
☐	Child abuse – sexual	☐	Palpitations / panic attacks
☐	Child abuse – emotional	☐	Perfectionist
☐	Child abuse - neglect	☐	Poorly organized
☐	Concerns with sexual activity	☐	Poor self-control
☐	Crying spells	☐	Problems with concentration
☐	Decreased energy and motivation	☐	Purges (vomiting, diuretics)
☐	Delusions	☐	Racing thoughts
☐	Depressed or sad	☐	Shortness of breath
☐	Destructive	☐	Self-harm
☐	Difficulty making decisions	☐	Sleep difficulties
☐	Dizziness	☐	"Spaces out"
☐	Easily frustrated	☐	Startles easily
☐	Emotional reactions	☐	Stomach trouble
☐	Fails to complete tasks	☐	Thoughts of hurting others
☐	Fatigue	☐	Thoughts of hurting self
☐	Fear of weight gain	☐	Thinking slowed
☐	Feelings of guilt and worthlessness	☐	Traumatic experience
☐	Feelings of hopelessness	☐	Tremors
☐	Feelings of inferiority	☐	Trouble making/keeping friends
☐	Feeling shaky, restless	☐	Unusual fears
☐	Flashbacks	☐	Unable to relax
☐	Forgetful	☐	Withdrawn
☐	Grandiose	☐	Others (please note below):
☐	Hallucinates	☐	
☐	Headaches	☐	
☐	Nausea	☐	

What brings you to counseling? Do you have any specific goals?**:**

____

____

Previous treatment history

Have you seen other mental health professionals? Include any hospitalizations, and dates if possible:

____

____

Substance abuse (please list any substances, including alcohol and cigarettes, you have used):

Substance	Name / Type	Age / 1st Use	Frequency	Age / last use

Does anyone in your family have a history of substance abuse? Please explain:

____

____

Please list any recent major changes (e.g., death, separation/divorce, move, traumatic event, etc.):

____

____

The information I provided here is true and complete to the best of my knowledge. This information will be kept confidential by my therapist, and only used to establish treatment in the counseling program at United Action for Youth. If my contact information, symptoms, or other important information changes, I will inform my therapist promptly.

Signed: ____ Date: ____________

United Action for Youth

CREATE | GROW | LEAD

Statement of Client Rights and Consent to Treatment

The UAY Counseling Program is a voluntary program that provides therapy and support services to youth and families. Program participants have the right to end services at any time. As a participant in the Counseling Program you have the following rights and responsibilities:

Participant's Rights:

- You and your belongings will be treated with unconditional positive regard (respect) by United Action for Youth staff.
- You will be treated fairly, honestly, ethically and responsibly without regard to race, color, creed, religion, gender, age, national origin or disability.
- You will be notified if your Therapist is unable to attend your scheduled appointment.
- You will have your information kept confidential unless you have provided written permission for information to be shared, or in the case of imminent harm or danger to you or a member of your family, or in the case of suspected child abuse or neglect.
- You may review your case file upon written request to UAY or your Therapist.
- Meetings will be scheduled at times that are convenient for you and your Therapist

Participant's Responsibilities:

- Treat UAY Therapist with unconditional positive regard (respect).
- Contact your UAY Therapist at 319-338-7518 if you are unable to keep an appointment.

Communication

Therapists are often not immediately available by telephone. While usually in the office between 9 AM and 5 PM, Monday through Friday, your call may go to voicemail if your therapist is with a client or otherwise engaged. Please suggest some times when you will be available in your message. If you are unable to wait for a return call and are experiencing a mental health emergency, please contact or go to the nearest emergency room, or call 911.

- In some cases, electronic communications, such as email and text messaging, may be used to communicate with your therapist. These are not to be considered emergency contacts or crisis lines. In-depth conversations about your mental health and wellbeing should be avoided when communicating electronically to protect your confidentiality.

- Electronic communications will not be responded to after hours, on weekends, or during holidays. All messages sent during these times will be answered during the next business day.

- A voice messaging service is available for after hour calls. If you have a non-life threatening emergency, call 319-338-7518, dial 1 when prompted and you will be connected to an On-Call Counselor, available 24/7.

Benefits and Risks of Therapy
Engaging in therapy can have many benefits. Your therapist can help you identify your strengths and find ways to use them to cope with your life, or develop new coping skills. You may find that you learn more about your reactions, relationships, and emotions. Your therapist can also help you to make desired choices and changes. You may experience a reduction of negative feelings (anger, guilt, shame, etc) or a reduced impact on your daily life from these feelings.

Therapy has potential emotional risks as well. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with your therapist to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful, and your therapist will always act in your best interest.

Client-Therapist Relationship Expectations
With the exception of their work at the youth center or at community events, your therapist will not engage in any relationship with you outside of the context of your therapy together. This means that you will not see each other socially or have a relationship on social media. You and your therapist can decide together how to manage situations where you may unintentionally see each other outside of therapy, including the youth center, in a way that acknowledges your right to confidentiality and your therapist's ethics.

Counseling Program Grievance Procedure
If you believe your rights have been denied, or you would like to express complaints, suggestions, grievances or concerns regarding services you have received through your participation in the Counseling Program, you may do so without the fear of punishment or discrimination. We encourage you to share your concerns directly with staff. If you feel the issue has not been resolved please contact:

Talia Medlinger, LISW
Counseling Program Coordinator
United Action for Youth
410 Iowa Avenue
Iowa City, IA 52240

If you are unable to resolve the issue with the Counseling Coordinator an appeal may be directed to the Executive Director at the same address listed above.

________________________ ___________________________ _____________

Participant Signature | Therapist Signature | Date

Confidentiality Policy

What is shared with a UAY staff person or UAY volunteer is confidential, whether you are an adult or a young person. It is important that everyone has someone with whom they can share a concern, tell something private or get ideas on a troublesome situation. Young people and their families can do so at UAY without information being shared with the rest of their family, their school, or others in the community, unless written permission is given.

There are exceptions to this policy:

1.) **CHILD ABUSE:** UAY Staff and Volunteers must report all forms of child abuse.
2.) **SUICIDE:** UAY Staff and Volunteers will do everything possible to keep people from hurting themselves. That may mean calling parents, the police or getting someone to the hospital.
3.) **DANGER TO OTHERS**: If a UAY staff or Volunteer believes there is clear and immediate danger to another person, they will make a report.
4.) **COURT ORDERED:** UAY will have to disclose information pertinent in any open child abuse case or when required by a Court of Law.
5.) **CASE PROCESSING**: UAY Staff will consult with other staff for case processing and supervision purposes only.
6.) **MEDICAL EMERGENCY:** UAY Staff will seek medical assistance in the event of a program participant's medical emergency.
7.) **WAIVER:** The program participant waives the privilege of confidentiality by bringing charges against UAY.

I understand that UAY staff will be contacting me via letter, email, phone, or text messaging and that my personal information will be confidential.

I have read and understood UAY's Confidentiality Policy. I know that UAY will report child abuse, suicide risk, and danger to others. I also understand that UAY provides information to funding sources, which may include age, gender, race, income and other statistical information, but does not include my family members' names. I willingly agree to accept services from United Action for Youth.

______________________________	______________________________	____________
Participant Signature	Participant Name	Date

Cancellation and No-Show Policy

Cancellation Policy:

In the event that you are unable to attend a scheduled appointment, we ask that UAY is given a 24-hour notice to cancel or reschedule. If a late cancellation is made 3 times in a row, you and your therapist will review this policy and discuss future appointment options.

No Show Policy:

If you miss a scheduled appointment without prior notice, you and your therapist will review this policy and work together to address any barriers you may be facing that affect your ability to attend scheduled appointments. After 3 no-shows, your therapist reserves the right to remove you from their active caseload. If at anytime you wish to resume therapy, you may call to set up a time to talk with your therapist about reinitiating services.

Exceptions:

We understand that things come up and schedules can, at times, be unpredictable. Our therapists will handle these policies on a case-to-case basis. A final decision will not be made without seeking your feedback and attempting to address any potential barriers that may prevent you from accessing services.

________________________	________________________	__________________
Youth Participant	Parent/Guardian	Date

Authorization & Assignment Form

This form, when completed and signed by you, authorizes United Action for Youth to release protected information from your clinical record to your insurance company. *Please provide your signature on BOTH of the sections below.*

Authorization to Share Information

I authorize my therapist at United Action for Youth to send patient information to my insurance company.

This authorization shall remain in effect until my treatment is completed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address and to the named recipient of the disclosed mental health information. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand I have the right to inspect the disclosed mental health information at any time.

I understand Iowa law prohibits redisclosure by the recipient of the information used or disclosed pursuant to this authorization.

____ ______________________

Signature of Patient or Guardian Date

Assignment of Benefits

I hereby authorize payment directly to the above named facility of the payments otherwise directly payable to me.

____ ______________________

Signature of Insured Date

INSURANCE/ FINANCIAL RESPONSIBILTY INFORMATION

Medical Insurance Coverage: You are responsible for payment of services. You may have insurance that pays some or all of our charges, but that is a matter solely between you and your insurance company.

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. You must realize, however, that your insurance is a contract between you and your insurance company. Not all services are covered by every insurance policy. While the filing of insurance claims is a courtesy we extend to our clients, all charges are your responsibility from the date the services are rendered. All charges are assessed a 3% service fee after 60 days. ***We require that your copayment be paid at the time of services rendered.*** *If you do not know what your copayment may be, check with your insurance company. Be sure to specifically ask about benefits for outpatient mental health counseling. Full payment at the time of service is required if you do not want your insurance billed.*

Payment Policy: We accept cash, check, money-order, Visa or Mastercard. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our office staff as promptly as you can for assistance in management of your account. If we do not hear from you within 90 days of service, your account may be turned over to a 3rd party for collection or continuing services may be reduced or denied.

Missed Appointments: Once an appointment is scheduled, you may cancel for any reason. Since we can accept only a limited number of clients, our time is precious. A **late cancellation or missed appointment** is a loss to us and to those waiting for appointments. If you need to cancel an appointment, **we ask that call at least 24 yours in advance. If you miss an appointment you may be charged a no-show fee.** We do understand circumstances may arise that are beyond your control, and we will consider each situation on a case by case basis. Please understand that your insurance benefits do not apply for missed sessions and you will be responsible for the no-show fee as an out of pocket expense.

Client name: ______________________Date of Birth: _____________Gender: M F ___

Person responsible for payment____

Address, City, State, Zip: ____

Phone number: ____________________________ Email: _______________________

I have read your insurance and payment policy and agree to accept the responsibility of payment in full for the services rendered.

____
Signature of Responsible Party Date

Continue to the next page to provide your insurance information.

POLICY HOLDER INFORMATON

Name (Last, First, Middle initial): ____

Date of Birth: ___________________________ Gender: Male Female ___________

Address: ____

City: ______________________________ State: ________ Zip: _____________

Phone Number: ______________________ Relationship to client:_________________

PRIMARY POLICY INFORMATION

Insurance Company: ____

Policy Number: ____________________________

Attach copy of your insurance card, both front and back of the card.

If you have coverage under more that one insurance policy, please complete information for each separate policy. If you need more space, please ask for another page.

POLICY HOLDER INFORMATON

Name (Last, First, Middle initial): ____

Date of Birth: _______________________Gender: Male Female _____________

Address: ____

City: ______________________________ State: ______Zip: ______________

Phone Number: _____________________Relationship to client:_________________

POLICY INFORMATION

Insurance Company: ____

Policy Number: ____________________________

Attach copy of insurance card, both front and back of the card.