WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Child Intake

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: _____ Current Age: ___ Gender: _____

Race/Ethnicity: _____ Preferred Language: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ SSN: _____

Email: _____ Phone: _____

Religion: _____

Preferred method of contact: voice: ☐ text: ☐ email: ☐

Parent/Guardian's Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Occupation: _____

Parent/Guardian's Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Relationship to client: _____

Who referred you to Waypoint Mental Health Counseling: _____

Reason(s) for seeking behavioral health services:

_____

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Medical

Primary Care Physician/Pediatrician: _____ Not Yet Established: ☐

Psychiatrist: _____ Not Yet Established: ☐

Dentist: _____ Not Yet Established: ☐

other physicians: _____

Does client have allergies? Yes: ☐ No: ☐ Unknown: ☐

If so, provide the names of allergies and any allergic reactions:

_____

_____

Is client currently being treated for any illness or injuries? Yes: ☐ No: ☐ Unknown: ☐

If so, explain:

_____

_____

Does client have any significant medical conditions? Yes: ☐ No: ☐ Unknown: ☐

If so, explain:

_____

_____

Has client had any surgeries or been hospitalized? Yes: ☐ No: ☐ Unknown: ☐

If so, provide reasons and dates:

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Please list all **CURRENT** physical medications, addiction medications, and psychotropic medications when listing current medications. None: ☐

Current Medications	Dosage	Frequency	Prescribing Physician

Please list all **PAST** physical medications, addiction medications, and psychotropic medications when listing past medications. None: ☐ Unknown: ☐

Past Medications	Dosage	Frequency	Prescribing Physician

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Does client have a current or a history of any of the following? If yes, please explain. Unknown: ☐

Head injury	No: ☐	Yes: ☐	_____
Broken bones	No: ☐	Yes: ☐	_____
Birth defects	No: ☐	Yes: ☐	_____
Poisoning	No: ☐	Yes: ☐	_____
Heart problems	No: ☐	Yes: ☐	_____
Kidney problems	No: ☐	Yes: ☐	_____
Liver disease	No: ☐	Yes: ☐	_____
Lung disease	No: ☐	Yes: ☐	_____
Blood disease	No: ☐	Yes: ☐	_____
Cancer	No: ☐	Yes: ☐	_____
Seizure	No: ☐	Yes: ☐	_____
Genetic disorder	No: ☐	Yes: ☐	_____
Diabetes	No: ☐	Yes: ☐	_____
Thyroid	No: ☐	Yes: ☐	_____
Neurological	No: ☐	Yes: ☐	_____
Skin	No: ☐	Yes: ☐	_____
Lyme disease	No: ☐	Yes: ☐	_____
Impaired sight	No: ☐	Yes: ☐	_____
Impaired hearing	No: ☐	Yes: ☐	_____
Eating disorder	No: ☐	Yes: ☐	_____
Sleep apnea	No: ☐	Yes: ☐	_____
Severe vomiting	No: ☐	Yes: ☐	_____
Frequent choking	No: ☐	Yes: ☐	_____
Other problems	No: ☐	Yes: ☐	_____
Speech difficulty	No: ☐	Yes: ☐	_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Indicate client's use of the following substances used daily. None: ☐ Unknown: ☐

Tobacco: _____ Marijuana: _____ Methamphetamine: _____

Opioids: _____ Cocaine: _____ Alcohol: _____

Other: _____

Is client interested in receiving treatment services for tobacco and/or other substances? Yes: ☐ No: ☐

Please check the symptoms that the client is currently experiencing:

☐ Hyperactivity	☐ Stress	☐ Anger/Aggression
☐ Sleep Problems	☐ Disability	☐ Alcohol/Drugs
☐ Cutting	☐ Depression	☐ Anxiety
☐ Destruction of Property	☐ Self-Confidence	☐ Loneliness
☐ Animal Cruelty	☐ Grief	☐ Parents
☐ Fire Setting	☐ Social Isolation	☐ Bed Wetting
☐ Increase/Decrease Appetite	☐ Legal Issues	☐ Stomach Aches
☐ Intrusive thoughts of past	☐ Problems at work	☐ Problems at school
☐ Repetitive Thoughts	☐ Fears/Phobias	☐ Compulsive Behaviors
☐ Medical Problems	☐ Relationships	☐ Strange Thoughts
☐ Sexual/Promiscuity	☐ Repetitive Behaviors	☐ Headaches
☐ Issues Memory	☐ Hallucinations	☐ Delusional Thinking
☐ Concentration	☐ Suicidal thoughts/plans/attempts	

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Has client ever been diagnosed with a mental illness? Yes: ☐ No: ☐ Unknown: ☐

If yes, what was the diagnosis:

_____

_____

_____

Has client ever been hospitalized for mental health? Yes: ☐ No: ☐ Unknown: ☐

If yes, provide the name and location of facility. Also, provide the reason for being hospitalized and the outcome:

_____

_____

_____

Has client ever attempted suicide and/or purposely cut or burned self? Yes: ☐ No: ☐ Unknown: ☐

If yes, please explain:

_____

_____

_____

Please describe your current concerns:

_____

_____

_____

Has there been significant stressors for the family (losses, births, deaths, moves, hospitalizations, financial problems) that may be impacting client's mental health? Yes: ☐ No: ☐

_____

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

What attempts have been made to resolve the difficulties?

_____

_____

_____

What are the specific behaviors, feelings, problems and/or functioning you hope to improve/goals of treatment?

_____

_____

_____

Has client ever received outpatient mental health counseling? Yes: ☐ No: ☐ Unknown: ☐

If yes, provide the name of provider, location of services, and dates of services:

_____

_____

_____

Family information

Is client currently residing in a non-kinship foster home? Yes: ☐ No: ☐

Is client adopted? Yes: ☐ No: ☐ If so, date of adoption: ☐ age at adoption: ☐

Family members and/or non-relatives living at home:

Name	Age	Gender	Relationship to Child

Client Name: _____

Identifier: _____

Has anyone in client's family experienced a psychiatric illness? Yes: ☐ No: ☐ Unknown: ☐

If yes, explain and identify which family members:

_____

_____

_____

Does anyone in client's family have a history of addictive disorders? Yes: ☐ No: ☐ Unknown: ☐

If yes, explain and identify which family members:

_____

_____

_____

Prenatal and Early Development

Age of mother at birth of child: ☐ Unknown: ☐

Child's birth weight: ☐ Unknown: ☐

Complications during pregnancy/delivery? Yes: ☐ No: ☐ Unknown: ☐

If yes, explain:

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Describe client during the first 6 months: If necessary, explain your answers. Unknown: ☐

Easy baby	Yes: ☐	No: ☐	_____
Enjoys people	Yes: ☐	No: ☐	_____
Irritable	Yes: ☐	No: ☐	_____
Difficult to sooth	Yes: ☐	No: ☐	_____
Sleep/wake cycle poorly regulated	Yes: ☐	No: ☐	_____
Unusually quiet	Yes: ☐	No: ☐	_____
Unusually sick	Yes: ☐	No: ☐	_____
Feeding difficulties	Yes: ☐	No: ☐	_____
Strong reaction to light/sound	Yes: ☐	No: ☐	_____
Strong reaction to touch	Yes: ☐	No: ☐	_____
Colic	Yes: ☐	No: ☐	_____

Did the following events occur at age-appropriate times? If necessary, explain your answers. Unknown: ☐

Sat without support	Yes: ☐	No: ☐	_____
Crawled	Yes: ☐	No: ☐	_____
Walked without support	Yes: ☐	No: ☐	_____
Used single words	Yes: ☐	No: ☐	_____
Used 2-3 word sentences	Yes: ☐	No: ☐	_____
Slept through the night	Yes: ☐	No: ☐	_____
Daytime wetting stopped	Yes: ☐	No: ☐	_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Social & Behavioral Development

Please answer the following as it relates to client. If necessary, explain your answers. Unknown: ☐

Initiates friendships	Yes: ☐	No: ☐	_____
Maintains friendships easily	Yes: ☐	No: ☐	_____
Interacts with children easily	Yes: ☐	No: ☐	_____
Interacts with adults	Yes: ☐	No: ☐	_____
Bullies Other children	Yes: ☐	No: ☐	_____
Destroys others' property	Yes: ☐	No: ☐	_____
Lies to other children	Yes: ☐	No: ☐	_____
Lies to adults	Yes: ☐	No: ☐	_____
Aggressive towards other children	Yes: ☐	No: ☐	_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Academic

Student Status: Not a Student: ☐ Part Time: ☐ Full Time: ☐

School: _____ Grade: _____

Teacher: _____ School Counselor: _____

Principal: _____

Please answer the following as it relates to the client. If yes, explain. Unknown: ☐

repeated a grade	No: ☐	Yes: ☐	_____
On an IEP	No: ☐	Yes: ☐	_____
academic concerns	No: ☐	Yes: ☐	_____
behavioral problems	No: ☐	Yes: ☐	_____
Suspensions	No: ☐	Yes: ☐	_____

Other academic and/or behavioral concerns:

_____

_____

_____

_____

Sleep Patterns

Please answer the following as it relates to the client. If necessary, explain your answers. Unknown: ☐

Stays asleep all night	No: ☐	Yes: ☐	_____
Gasps for air when sleeping	No: ☐	Yes: ☐	_____
Feels rested after sleep	No: ☐	Yes: ☐	_____
Nightmares	No: ☐	Yes: ☐	_____
Gets adequate sleep	No: ☐	Yes: ☐	_____
Falls asleep easily	No: ☐	Yes: ☐	_____
Consistent sleep patterns	No: ☐	Yes: ☐	_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Please **INITIAL** all **nine** of the following areas to acknowledge receipt:

_____ Code of ethics

_____ Consumer Bill of Rights

_____ Consumer Expectations

_____ Confidentiality of Consumer Records

_____ HIV/AIDS/STD Referral Information

_____ Orientation Information

_____ Complaint/Grievance Procedure

_____ HIV/AIDS/STD Education Session

_____ HIPAA Notice

Do you want to receive the full Bill of Rights? Yes: ☐ No: ☐

Is Consumer under the age of 21? Yes: ☐ No: ☐

Would you like additional information and/or counseling on HIV/AIDS/STD? Yes: ☐ No: ☐

May Waypoint Mental Health Counseling contact you after completion of treatment regarding your satisfaction of services? Yes: ☐ No: ☐

Does Waypoint Mental Health Counseling have permission to transport your child for the purpose of receiving services? Yes: ☐ No: ☐ N /A: ☐

(If applicable) In the event that a medical emergency occurs while my child is with a Waypoint Mental Health Counseling representative, and it's not possible for me to consent to medical treatment, I hereby authorize a Waypoint Mental Health Counseling representative to seek appropriate medical treatment for my child. I also give permission for attending personnel to execute on my behalf, permission forms or other medical documents, and to act on my behalf.

Waypoint Mental Health Counseling is a Medicaid fee for service provider and all fees are covered by Medicaid if the consumer is eligible. On occasion it may be necessary for a licensed person to reassess and/or update clinical information regarding plan or treatment.

The undersigned acknowledges receipt of the **Consumer Handbook** which has been communicated in a meaningful way. The consumer read and understands this document in its entirety and agrees to the terms and provisions stated herein. The consumer also acknowledges receipt of **Notice of Privacy Practices** which identifies uses of health information for the purpose of treatment, payment, and Waypoint Mental Health Counseling operations. The Notice of Privacy Practices also explains in detail how and to whom Waypoint Mental Health Counseling may share consumers health information with other than treatment, payment, and health care operations. The Notice of Privacy Practices explains in detail why Waypoint Mental Health Counseling may share consumers health information as required/permitted by law. By signing below, the consumer and/or Guardian is giving **consent** for treatment at Waypoint Mental Health Counseling.

Client Name:_____ Medicaid#: _____

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you may gain access to this information.

Waypoint Mental Health Counseling will protect the privacy of your health information and follow all state and federal laws. You have privacy protection under Medicaid and Oklahoma Laws. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, ourlegal duties and your rights concerning your health information. This letter tells you about your privacy rights and what may be done with your health information by law.

Right to inspect and copy: You have a right to see and gain a copy of the health information in your records. It will not include information needed for civil, criminal, administrative actions and proceedings or psychotherapy notes.

Right to request an amendment: If you feel the health information documented is wrong or incomplete, you may ask your therapist in writing to adjust this information. Your therapist has the right to deny your request if it is not in writing and it does not include a reason, or the information was not created by your therapist, or the information is determined to be correct and complete.

Right to an accounting of disclosures: You have the right to request an "accounting of disclosures," a list of names that your health information has been given to, other than disclosures for the purpose of treatment, payment, or operations.

Right to request restrictions: You have the right to ask your therapist to either not give or partially give your healthcare information used for treatment, payment, or health care operations. Your therapist is not required to comply. However, ff agreed, your therapist will follow your request for restriction except when emergency care is necessary.

Right to request confidential communication: You have the right to ask your therapist to discuss with you, your healthcare matters in a certain way or at a certain place. For example, you may ask that your therapist only contact you at work or by email. Your therapist will work to meet all reasonable requests.

Right to a paper copy of this notice: You have a right to ask for a paper copy of this notice. To use these rights, a request for inspecting, copying, and amending, making restrictions, or obtaining an accounting of your health information must be made in writing to Lindsey Logan at 823 N Jim Thorpe BLVD. Prague, OK 74864.

How your health care information may be used and disclosed:

Appointment reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail and text messaging).

For Operations: Waypoint Mental Health Counseling can use and give information about you to make sure that services and benefits you get are correct and high quality. We may share health information with business partners. Waypoint Mental Health Counseling partners are licensed professionals who are required by law to ensure privacy and security in handling health care information.

For payment: Information about you may be given to your health plan or health insurance carrier to pay for your services. Your case may be shared with government programs such as worker's compensation; Medicaid, your insurance, or Indian Health Services to better manage your benefits and payments.

For health oversight activities: Your health information may be shared with other agencies for oversight activities required by law. Examples might be audits, inspections, investigations, and licensure.

Legal obligation: Your health information may be given to a law enforcement official, subject to applicable federal and state law regulations, purposes that are required by law or in response to a court order or subpoena. If you are involved in a lawsuit or dispute your information may be given in response to a court or administrative order.

To avert a serious threat to health or safety: If necessary, your information may be released to prevent serious threat to your health and safety of others.

Duty to the Military: If you are a Veteran or member of the armed forces, your health information may be given as required by military command or Veteran administration authority.

As required by law: Your health information may be shared when required to do so by federal, state or local law. State and Federal laws require Waypoint Mental Health Counseling maintain theprivacy of your health information and to provide clients this notice of legal duties and privacy practices. If you believe your rights have been violated you may file a complaint by writing to Oklahoma Health Care Authority, 4545 North Lincoln Boulevard, Suite 124, OKC, OK 73120.

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Consumer Bill of Rights

- Consumer has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights.
- Consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
- Consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, and age, degree of disability, handicapping condition or sexual orientation.
- Consumer shall not be neglected or sexually, physically, verbally, or otherwise abused.
- Consumer shall be provided with prompt, competent, and appropriate treatment and an individualized treatment plan.
- Consumer shall participate in treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law.
- Consumer may allow other individuals to participate in treatment.
- Consumer is to be free from unnecessary, inappropriate, or excessive treatment.
- Consumer will participate in treatment planning.
- Consumer can receive treatment for co-occurring disorders if present.
- Consumer is not subject to unnecessary, inappropriate, or unsafe termination from treatment.
- Consumer will not be discharged for displaying symptoms of disorder.
- Consumer's record shall be treated in a confidential manner.
- Consumer shall not be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
- Consumer shall have the right to assert grievances with respect to an alleged infringement on rights.
- Consumer has the right to request the opinion of an outside medical or psychiatric consultant at his/her own expense or a right to an internal consultation upon request at no expense.
- Consumer shall not be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his/her rights.
- Consumer has the right to file a confidential verbal or written grievance regarding treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. All complaints will be resolved within 30 days of the date of grievance. To file a grievance, you may:
    - Begin by informally contacting your therapist. If claim is not resolved within 5 business days, you may contact
    - Lindsey Logan, Coordinator and Local Grievance Advocate
      Waypoint Mental Health Counseling
      823 N Jim Thorpe BLVD.
      Phone: (405) 567-9929
      Fax: (405) 835-3945

The above rights are meant as a synopsis of the Mental Health and Drug or Alcohol Abuse Services Bill of Rights. A full copy of the rights, OAC 450:15-3-6 through 450:15-3-25, is available upon request.

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Financial Policy and Insurance Agreement

Payment Method: Payment is required at time of service. If you are utilizing your private insurance, co-pay(s) and deductible(s) are due at the time of service. Waypoint Mental Health Counseling accepts cash, checks, and credit cards. If a check bounces, you will be charged an additional $50.00 for each presentation to the bank.

Past Due Accounts: Any account past due will accrue a 1.5% monthly interest fee. A $5.00 re-billing fee will beassessed monthly if payments are not made by the payment due date.

Missed Appointments: If an appointment is canceled or missed without a 24-hour notice, you will be billed $50.00 that must be paid prior to having another appointment.

Responsible Party: If the client is a minor, the parent/guardian will be responsible for payment. Waypoint Mental Health Counseling will lattempt to collect payment from 3rd party payer(s), but if this fails, the client is responsible for payment.

Collections: All accounts 60 days overdue will be turned over to a collection agency or legal action unless apayment agreement can be reached. Personal information will be disclosed for necessary collections and/or legal action.

Good Faith Estimate: All private pay clients will receive an estimate of expected charges for counseling services. The estimated costs are valid for 12 months and will include the expected scope of the recurring primary items of services.

Primary Insurance Company:_____ Group Name:_____

Policy/Identification Number:_____ Group Number:_____

Policy Holder's name:_____ Policy Holder's DOB:_____

Secondary Insurance Company:_____ Group Name:_____

Policy/Identification Number:_____ Group Number:_____

Policy Holder's name:_____ Policy Holder's DOB:_____

By signing this document, you are authorizing payment of insurance benefits directly to Waypoint Mental Health Counseling and/or the mental health professional who is rendering services. You are also authorizing the release of any and/or all your information necessary for checking benefits, filing claims, pre-certification, concurrent review, and/or retroactive chart reviews. You are affirming the information regarding insurance coverage is accurate. If you are a private pay client, your signature acknowledges you have received a Good Faith Estimate compliant with the No Surprise Act.

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Electronic Information and Telehealth Communications

Electronic Information: Waypoint Mental Health Counseling may use an electronic patient notification system. This system is used to notify you of your appointment date/times, appointment reminders, practice alerts, (e.g., rescheduled appointments, unscheduled office closures due to severe weather, illness, etc.). The electronic notifications are sent via text message, email, and voice messages.

Telehealth Communications: Waypoint Mental Health Counseling offers telehealth services which involves the use of technology to deliver services to an individual who is located at a different site other than the mental health provider. Waypoint Mental Health Counseling uses HIPAA Compliant, secure video conferencing platforms to protect the privacy of clients. However, when sessions are conducted using audio only, secure platforms are not available

There are potential risks associated with the use of electronic information and communications. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video).
- Delay of session could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing a breach of privacy of personal information.

By signing below, I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for ensuring privacy at my own location. I understand secure platforms are not available when only using audio communication. Therefore, I understand that Waypoint Mental Health Counseling is not responsible for breach of confidentiality during audio sessions.

I have read and understand the information provided above regarding telehealth services and electronic communication. I hereby give my informed consent for the use of telehealth services and electronic communication.

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Consent For Treatment

Application is hereby made by the undersigned for voluntary admission to the services at Waypoint Mental Health Counseling as a voluntary consumer under the provision of OS 43A. Section 9-101

Voluntary admission may be made for any person eighteen (18) years of age or over on his/her own signature. Any person at least sixteen (16) years of age may be admitted with the consent of such person and the consent of the person's parent or guardian, OS 43A. 5-304.

I have read, or had read to me, the following information about my rights.

All persons receiving services from this facility shall retain the rights, benefits, and privileges guaranteed by the laws and constitutions of the State of Oklahoma and the United States of America, except those specifically lost through due process of law. OS 43A, Section 1-103(h).

All persons shall have the rights guaranteed by OK Dept of Mental Health and Substance Abuse Consumer's Bill of Rights unless an exception is specially authorized to these standards or an order of a court of competent jurisdiction.

I have been given a summary or full copy of my rights as a consumer and fully understand the content of this document.

I understand that my treatment records may be subject to review by funding sources and accrediting bodies to verify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each consumer of the agency be charged for care and treatment provided. An individual will not be refused needed treatment because of inability to pay, OS 43A, Section 4-202.

By signing below, the consumer is giving **consent** for treatment at Waypoint Mental Health Counseling

Client's DOB:_____

Medicaid#: _____
(if applicable)

Client Name: _____

Guardian Name: _____
(if applicable)

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)

Witness (Mental Health Professional): _____ Date: _____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Authorization for Release of Information

I, _____, hereby authorize Waypoint Mental Health Counseling to release and/or obtain the following information in:

☐ my records ☐ my child's records: _____ _____
Child's Name (if applicable) Client's DOB

☐ Psychiatric records ☐ Medical related information ☐ School related information
☐ Psychological assessment ☐ DHS/Case Worker Reports ☐ Legal/Court documents
☐ Other: _____

This information is to be ☐ released to ☐ obtained from

Name of Individual/facility: _____

Contact Information: _____

This authorization will expire: ☐ 12 months ☐ other (specify date) _____

Information is being released for the following purpose: _____

Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re-disclosure by the recipient, resulting in the information no longer being protected. Services are not contingent upon the consumer's decision concerning authorization for the release of information.

I understand that my insurer requires certain information regarding treatment, I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the protected healthinformation related to mental health. Release of mental health records or psychotherapy notes may require the consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse treatment records. This specific category of medical information/record is protected by Federal law, (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further releases unless further release is expressly permitted by the written authorization of the client or is permitted by Federal Law, (42CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol/drug abuse client. The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease. As a result, by signing below, I specifically authorize any such records in my health information to be released.

Name of Client: _____ Name of Guardian: _____
(if applicable)

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(if applicable)

Witness (Mental Health Professional): _____ Date: _____

ASQ

Ask Suicide-Screening Questions

Client Name: _____

Identifier: _____

ages 3-10

Date: _____

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ☐ Yes ☐ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ☐ Yes ☐ No
3. **In the past week, have you been having thoughts about killing yourself?** ☐ Yes ☐ No
4. **Have you ever tried to kill yourself?** ☐ Yes ☐ No

   If yes, how?

   _____

   _____

   When?

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ☐ Yes ☐ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**

☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)

- **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
- Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)

- **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
- Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Patient Health Questionnaire (PHQ–9)

Client Name: _____

Identifier: _____

Date: _____

ages 11-17

Total Score: _____

1. Over the last two weeks 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 TV.	☐	☐	☐	☐
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 more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score: _____

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

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

TREATMENT PLAN DEVELOPMENT SIGNATURE PAGE

The client and/or guardian have actively participated in the development of this Treatment Plan and understand the goals and objectives.

Client/Guardian: ☐ agrees ☐ disagrees

Comments and/or response:

Signature of Client (age 14 and older): _____ Date: _____

Signature of Parent/Guardian: (if applicable) _____ Date: _____

Witness (Mental Health Professional): _____ Date: _____

Witness (Mental Health Professional): (if two clinicians are participating in treatment) _____ Date: _____