WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Adult Intake

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

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

Race/Ethnicity: _____ preferred language: _____

Address: _____ City: _____

State:_____ Zip: _____ SSN: _____

Phone:_____ Email address:_____

Religion: _____

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

Emergency Contact Name: _____ Relationship:_____

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

Phone:_____ Occupation: _____

Does consumer have a treatment advocate? Yes: ☐ No: ☐

If so, provide treatment advocate's name and contact information:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Occupation: _____

Who referred you to Waypoint Mental Health Counseling: _____

Reason (s) for seeking behavioral health services:

_____

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

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 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:

_____

_____

_____

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:

_____

_____

_____

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Childhood Family Information

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

Are childhood experiences currently impacting your life: Yes: ☐ No: ☐

Describe client's living environment as a child (check all that apply):

Normal home environment: ☐

Chaotic home environment: ☐

Outstanding home environment: ☐

Witnessed physical/verbal/sexual abuse: ☐

Experienced physical/verbal/sexual abuse: ☐

Who was present during childhood (check all that apply):

biological father: ☐ biological mother: ☐ Biological siblings: ☐

adoptive father: ☐ adoptive mother: ☐ adoptive siblings: ☐

stepfather: ☐ stepmother: ☐ stepsiblings: ☐

Father: living: ☐ deceased: ☐ unknown: ☐

mother: living: ☐ deceased: ☐ unknown: ☐

Current Relationship Status:

Current marriage status (check all that apply):

married: ☐ divorced: ☐ widowed: ☐ separated: ☐

Is client satisfied with current relationship status: Yes: ☐ No: ☐

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Describe relationship with children. (please explain your answers):

Healthy: Yes: ☐ No: ☐ _____

Inconsistent: Yes: ☐ No: ☐ _____

Non-active: Yes: ☐ No: ☐ _____

Family members and/or non-relatives living in the home:

Name	Age	Gender	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

School/Education

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

Current and/or past academic concerns:

_____

_____

Work History

Current Employer: _____ Job Title: _____

Length of Employment: _____ Have you ever been fired from a job: Yes: ☐ no: ☐

Are you satisfied with your current occupation: Yes: ☐ No: ☐

WAYPOINT
MENTAL HEALTH COUNSELING

Client Name: _____

Identifier: _____

Please **INITIAL** to verify receipt of the following:

_____ 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 chave 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.

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, concurrentreview, and/or retroactive chart reviews. You are affirming the information regarding insurance coverage is accurate.

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 specificallylost 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 competentjurisdiction.

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 toverify and evaluate services delivered.

I understand that OS 43A, Section 4-201 requires that each consumer of the agency be charged for care andtreatment 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: _____

Right to Name a Treatment Advocate

According to Oklahoma State Law 43A-1-109.1:

- Every adult having a mental illness as defined in Section 1-103 of this title who is under the care of a licensed mental health professional shall be informed by the licensed mental health professional or the mental health treatment facility that the consumer has the right to designate a family member or other concerned individual as a treatment advocate.
- The individual designated as a treatment advocate shall act at all times in the best interests of the consumer.
- The patient may change or revoke the designation of a treatment advocate at any time and for any reason.
- The treatment advocate may participate in the treatment planning and discharge planning of the consumer to the extent consented to by the consumer and as permitted by law.
- A person holding the powers vested in a guardianship of the person, a grant of general
- health care decision-making authority or designation of health care proxy contained in an advance directive for health care, or a durable power of attorney with health care decision making authority shall be the treatment advocate for the patient by operation of law.

Would you like to name a Treatment Advocate? ☐ Yes ☐ No

Please indicate the level of involvement the identified Treatment Advocate shall have:

☐ present during Intake ☐ assist with treatment planning ☐ present during all sessions

☐ written treatment plan ☐ notification of changes in treatment

☐ other: _____

As the client's treatment advocate, I understand that all mental health treatment information is confidential. By signing this form, I agree to maintain confidentiality to the extent in which the standards are described in the Waypoint Mental Health Counseling Consumer Handbook. I also understand the client may revoke the designation of a treatment plan advocate at any time.

Name of Treatment Advocate: _____ Phone: _____
(if applicable)

Signature of Treatment Advocate: _____ Date: _____
(if applicable)

Signature of Client: _____ Date: _____

Witness (Mental Health Professional): _____ Date: _____