HEALTH CONNECT AMERICA

Address: _____
Phone: _____ Fax: _____
Visit us online @ www.healthconnectamerica.com

REFERRAL FORM

Service or Program Requested: _____

Referring Agency Contact Information:
Name/Agency: _____
Relation to Client: _____
Phone: _____
Fax: _____
Email: _____
***Have you informed the person/family that you are referring them for services?* *Yes*____ *No*___

If Parent/Guardian/Self Referral: **Date:** _____
Who referred you: _____

Please list any diagnosis and code:
_____
School Attended and/or Place of Employment
_____
Is the person on any medications? Yes/ no
Please list: _____

Client: _____ **Date of Birth:** ____/_____/_____

Social Security Number: _____ **Gender: M** __**F** ___ **Nonbinary** ___ **Other**: _____

Race: ___**American Indian or Alaska Native** ___**African-American** ___**Asian** ___**Caucasian** ___**Latino**
____**Native Hawaiian or other Pacific Islander** ____**Bi-Racial** ____**Other** _____

Ethnicity: ____ **White, Non-Hispanic** ____ **Hispanic or Latino** ____**Not Hispanic or Latino**

Legal Status: ____**Citizen** _____**Alien** **Tobacco Use:** ____**User** ____**Non-User** ___**Unknown**

If Tobacco User: **Smoking Status Is:** ____**Current Everyday** ____**Current Some Days** ____**Former Smoker** ____**Never Smoked**
____**Heavy Tobacco Smoker** ____**Light Tobacco Smoker (check all that apply)**

If client is underage or Adjudicated Incompetent as Adults: Parent /Guardian: _____

Relationship: _____ **E-mail:** _____

Client Address: _____ **City** _____ **Zip Code** _____

Home Phone Number: _____ **Work Phone:** _____ **Cell Phone:** _____

Please provide brief explanation of concerns/symptoms or reason for referral to services: _____

_____

_____

_____

_____

_____

_____

Other relevant information about this referral: _____

_____

Insurance Information: Type of Insurance: _____
Member ID Number: _____ Term Date: _____
Is there a secondary insurance? Yes No
If yes, please indicate company and type of plan. _____
Has a letter of service denial been received from second insurance? _____ Date Received _____

Individual Office Use Only (name boxes as desired): ☐_____ ☐_____ ☐_____ ☐_____ ☐_____ ☐_____

Informed Consent Form

Individual: _____ Date: _____

About the Therapeutic Relationship

The main purpose of this service is to help identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strengths.
2. Identifying specific and individualized goals.
3. Taking personal responsibility to make the changes necessary to attain your goals.
4. Utilizing all available community, medical and self-help resources.

The relationship between the Company Staff Member and individual is the container through which individual change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. Typically, the therapeutic relationship begins when treatment begins, and ends when treatment ends. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room. In addition, Company Staff Members and individuals/guardians are never to have contact via any social media.

Appointment

Scheduling is between the Company Staff Member and the individual/family receiving services. Most services we provide have limits on frequency and length of each session. We will make every effort to schedule services when it is most helpful to you and when it will best facilitate goal advancement and completion. Please refer to the Program Description sheet for detailed information about the service(s) you will receive.

Confidentiality

Issues discussed in therapy are important and are generally legally protected. Confidentiality is defined as not telling what is discussed in session, whether it be a one-on-one session or a group session. However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When it is believed an individual is in danger of self-harm.
3. If an individual intends to physically injure someone, the law requires Company staff to inform that person as well as the legal authorities.
4. If ordered by a court to release information.

Each individual and/or guardian will be asked to sign a Release of Information so that Company Staff Member may speak with other healthcare professionals, child welfare services workers, or to family members.

Company staff shall ensure that all personal electronic devices, such as computers, laptops, pads, tablets phones, etc., used to communicate with individuals, or store individual information, are password protected at all times.

Record Keeping

A clinical chart is maintained describing counseling goals and progress, dates of sessions, and notes describing each session. Records will not be released without written consent, unless in those situations as outlined in the Confidentiality section above.

Treatment Agreement

It's important to develop a treatment/service plan so that both the Company Staff Member and individual/guardian know what goals are being addressed. Usually the first three sessions are understood as assessment sessions during which time we need to decide what the issues will be addressed and what kind of interventions will be best for you. A referral to an outside support group or treatment program may be suggested or required. At times you will be asked to complete assignments outside of the therapy hour. The outside assignments are essential aspects of your treatment and failure to follow through may impair the Company Staff Member's ability to be helpful to you. You are expected to take an active role in the therapeutic relationship, which includes regular feedback to your Staff Member as to your progress. Treatment surveys will be provided at discharge for feedback.

Consent for (mark all that apply):

☐Outpatient ☐In-Home ☐Substance Use Services ☐Case Management ☐Medication Management

☐Other (Specify): _____

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction, including an explanation of any benefits, risks, side effects and alternatives to the services to be provided.

I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or the therapeutic relationship. I understand that I may withdraw from therapeutic relationship at any time.

My signature also indicates that I give permission to Company to leave messages for **scheduling purposes, surveys, and telehealth links** at the following telephone number_____ and/or email address _____.

Select which methods of communication for the above number are allowed:

☐Voice Mail ☐Text Message ☐ Email Message

For your protection, emails and texts can be hacked so it is important that confidential information not be discussed on these platforms. Instead please call or wait to address topics in sessions.

_____ _____

Child or Individual Date

_____ _____

Parent/Guardian/Authorized Representative Date

Authorization for Release of Information

Client Name: _____ Birth Date: _____

I hereby authorize_____ (or designee) to:
Person or Position

Discuss with _____ Send to _____ Receive information from _____

Name: _____Phone: _____Address: _____

For the purpose of: _____

Information to be released:

		____Claims/Encounter Data
_____Medical evaluation	_____Treatment Plan	____Diagnostic Information
_____Psychiatric evaluation	_____Laboratory/ UDS results	____Medication & Dosages
_____Social history	_____Educational/Special Ed Records	____Allergies
_____Psychosocial	_____Court Records	____Substance Use Hx Summary
_____Discharge summary	_____Progress Notes	____Trauma Hx Summary
_____Treatment/Case Summary	_____Assessment and Recommendations	____Employment Information
_____Other: _____	_____Other: _____	____Living Situation/Social supports

("HIV/AIDS Information" and "Substance Abuse information" must be separately and specifically listed on the "Other" line in order to release this information)

Type of Release/Expiration: (check the one that applies)

_____**One-time release**--the date the release expires is not to exceed **90 days** from date authorization is signed.

_____**Ongoing Service Provision**--When a contracted or cooperating service provider requires the release of information for ongoing service provision not to exceed **one year**, or as the law or court order requires, from the date the authorization is signed.

Regarding the listed contact on this Authorization for Release of Information form, do you have any requests for restrictions with specific people or regarding specific information being released? (If yes, an additional form will be completed (Communication Restrictions Form and/or Disclosure Restrictions Form)

__yes __ no Request for Communication Restrictions (with specific people)

__yes __ no Request for Disclosure Restrictions (regarding specific information)

This authorization may be revoked at any time upon written notification from the client and/or the parent/legal guardian (excluding information released prior to the revocation). Additionally, the Company will not condition treatment, payment, enrollment or eligibility for benefits on the patient's consent, or the consequences for refusal to consent to the release of information.

This notice accompanies a disclosure of information concerning a patient in alcohol and drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by 42 CFR, Part 2. A general authorization for the release of other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute a client or patient.

Individual's Printed Name: _____Date: _____
Individual's Signature: _____
Parent's Printed Name: _____Date: _____
Parent Signature: _____

*Clients have the right to request a copy of the Release of Information

Authorization for Release of Information

Client Name: _____ Birth Date: _____

I hereby authorize_____ (or designee) to:
Person or Position

Discuss with _____ Send to _____ Receive information from _____

Name: _____Phone: _____Address: _____

For the purpose of: _____

Information to be released:

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Individual's Printed Name: _____Date: _____
Individual's Signature: _____
Parent's Printed Name: _____Date: _____
Parent Signature: _____

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Authorization for Release of Information

Client Name: _____ Birth Date: _____

I hereby authorize_____ (or designee) to:
Person or Position

Discuss with _____ Send to _____ Receive information from _____

Name: _____Phone: _____Address: _____

For the purpose of: _____

Information to be released:

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Individual's Printed Name: _____Date: _____
Individual's Signature: _____
Parent's Printed Name: _____Date: _____
Parent Signature: _____

*Clients have the right to request a copy of the Release of Information

Individual's Name: _____

Safety Plan

Step 1: Warning signs/triggers (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity, relaxing activity, things you enjoy):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____Phone_____
2. Name_____Phone_____
3. Place_____4. Place_____

Step 4: People whom I can ask for help:

1. Name_____Phone_____
2. Name_____Phone_____
3. Name_____Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Staff _____Phone_____
   Staff Emergency Contact #: _____
2. Clinic/Psychiatrist: _____Phone_____
   Clinic/Psychiatrist Emergency Contact # _____
3. Call 911 or go to ER: _____
   Emergency Room Address: _____
   Phone 911 or Mobile Crisis Phone #: _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

Remove guns/medications/substances/alcohol/other dangerous items by:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

Individual's Printed Name: _____ Date: _____
Individual's Signature: _____
Parent/Guardian's Printed Name (if applicable): _____Date: _____
Parent/Guardian's Signature (if applicable): _____

Individual: _____ DOB: _____

Preliminary Individualized Service Plan

Date: _____

Preliminary Diagnosis/Medical Diagnosis/Educational Classification:

_____

_____

Behavior: _____

_____

Goal #1: _____

_____

_____

Objective: _____

_____

_____

Objective: _____

_____

_____

Behavior: _____

_____

Goal #2: _____

_____

_____

Objective: _____

_____

_____

Objective: _____

_____

_____

Behavior: _____

_____

Goal #3: _____

_____

_____

Objective: _____

_____

_____

Objective: _____

_____

_____

_____ _____

Individual's Signature Parent/Guardian Signature

_____ _____

HCA Staff Signature HCA Supervisor Signature