1.8.19

CLIENT INTAKE
REFERRAL FORM

CAFY Case No: **Referred by:** **Counseling/Legal Service Only:_____**

Confidential Once Completed

VICTIM SERVICES: Complete this form and send to Crisis Intake Specialist for entering. CAFY Number will be assigned then.
COUNSELING CENTER: Complete this form to prepare for your clients visit: Once complete send to **cafycounseling@cafyonline.org**
LEGAL SERVICES: Complete for form and send to cafylegal@cafyonline.org

Date:	**Referred by:**	**Case Manager:**	
Clients Name/ Race:	**DOB:**	**Age:**	**Marital Status: M__ S__ D__ W__ SEP__**
Parent/ Guardian Name (if 17 or below)**:**		**How do you identify?**	
Employed: No__ Yes__ If yes, Employers Name_____ Emergency Contact: _____ Emergency Contact No. :_____			
Incident: (List the type of case)	**Offender's name:**		
Home Address:	**City:**	**State:**	**Zip Code:**
Telephone (H):	**(W):**	**(C):**	
May we leave messages at the numbers provided: Yes ___ No___			
PLEASE NOTE: Email correspondence is not considered a fully confidential method of communication **Email:**		**May we Email: Yes___ No___**	
Insurance: Private:_____ Medicaid_____	**Insurance Provider Name:**		
Insurance ID:	**Insurance Group No.:**		
Has your clients completed CICB? Yes: _____ No:_____ Claim #:	**Court Information, if applicable:**		

Please check one of the boxes for all clients:	**Annual Average** **__ $0 - $15,000** **__ $15,001- $30,000** **__ $30,001- $45,000** **__ $45,001- 50,000** **__$50,001- & above**	**Counseling Center Staff ONLY**

Client Fee	CAFY Initials	Date
Special arrangements?	Use payment sheet	

INTAKE QUESTIONS

1. No. of people in your household: _____ Ages:
2. If there are children involved, how do the children feel after the incident?
3. Has your living situation changed recently? Yes___ No____ If yes, how?
4. Do you feel safe where you live? Yes____ No _____ If no, why?
5. Is there any domestic violence or other safety concerns in the home? Yes___ No____ If yes, how?
6. Are there any medical, physical, or financial issues that may prevent you from leaving your home and coming to our office?
7. Do you fear that you will be harmed again or that this person poses an ongoing threat to your safety?
8. Would you like to be updated whenever your offender has a court case coming up?
9. Was there anyone else affected/involved that needed services?
10. Who would you classify as your support system?
11. Is that person aware of the incident that occurred? Yes___ No___ If yes, are they able to support you now?
12. Do you use alcohol? Yes____ No____ If so, how often?
13. How often do you engage in recreational drug/experiment with prescription medication? Daily__ Weekly__ Monthly__ Rarely__ Never__
14. Have you experienced any injuries that need or needed medical attention?
15. Have you lost financial support as a result of the incident? Yes___ No___ How?

16. Are there any illnesses we should be aware of?
17. Has there been any change in your family dynamics?
18. Has there been any past occurrence of trauma? Yes___ No___ If yes, is there any support that you would like available to you now?
19. [If appropriate] Are you in control of your own money or does someone manage that for you?
20. Is there any things else we need to know to better help assist you?

HOUSING

1. What is your current housing situation?
2. Are there any barriers to you finding housing?
3. Do you have family near?
4. Are you experiencing any financial challenges meeting your expenses?

COMPLETE IF REFERRING TO COUNSELING: Please complete this brief assessment with your clients prior to scheduling.

COUNSELING

1. What kind of challenges are you facing regarding this issue?
2. Describe any physical or emotional changes you have noticed?
3. Have you had any recent thoughts about self-harm or thoughts of suicide?
4. What about sleeping, working, doing regular day-to-day- chores, have you been able to continue or any other challenges?
5. What have you tried so far to handle this situation?
6. What would you like to accomplish out of therapy?
7. Fears or concerns of counseling?
8. Do you have a religious background? If so please name.
9. Do you prefer a male or female therapist?
10. Is there any additional information you would like the counselor to know.

COMPLETE IF REFERRING TO LEGAL: Please complete this assessment

LEGAL

Protective/ Peace Order:	**Child Support:**	**U-Visa:**
Custody:	**In School Transfer:**	**Other :**

Check Box:

1. Did the victim notify law enforcement? **YES:_____ NO:_____** If yes, what is the police report?_____
2. Did law enforcement suggest a plan of action for victim? **YES:____ NO:____** If yes, will they be following that? **YES:_____ NO:____**
3. Is this incident the first of its kind? **YES: _____ NO:_____**
4. Are there any witnesses to the crime? **YES: _____ NO:_____**
5. Has victim relocation because of incident? **YES:_____ NO:_____**
6. Has the offender threatened the victim, their family or friends since the incident? **YES:_____ NO:_____**
7. Are there issues of custody or guardianship because of the incident? **YES:_____ NO:_____**

Legal Referral:

- ❑ Sexual Assault Legal Institute (SALI)
- ❑ Community Legal Service
- ❑ Maryland Legal Aid
- ❑ Ayuda
- ❑ House of Ruth
- ❑ Maryland Crime Victim Resource Center
- ❑ CAFY Legal
- ❑ Other: _____

Services accepted by client:

CICB	___	**COURT COMPANIONSHIP**	___
VINE	___	**CLIENT ASSISTANCE FUND**	___
COUNSELING	___	**STEP**	___
HOUSING	___	**FINANCIAL EMPOWERMENT**	___
LEGAL	___	**HELPLINE**	___
HOME VISIT	___	**PATHS**	___
COURT EDUCATION	___		

SUMMARY:

GOALS:

1.
2.
3.
4.
5.

Client Information

NAME:_____DATE:_____D.O.B:_____

Parent's Name_____

Prior counseling (outpatient therapy, self-help programs, inpatient admissions, chemical dependency, etc. (please include approximate dates)_____

Please explain as best as you can your reason for coming here today._____

Presenting Issues (stress, problems/issues that may apply to you *or others in your family*.

If not yourself, please indicate which family members each category refers to)

Depression (1-10: mild→Severe)
Current suicidal thoughts/actions
Past suicidal thoughts/actions
___ Anxiety/panic attacks(1-10: mild→Severe)
Phobias
Problems focusing
Boredom
Decreased motivation
Chronic Fatigue
Painful/difficult emotions
Eating problems:

Withdrawn behavior/isolating
Job related difficulties
Financial Concerns
Loss of interest in activities
Career/vocational concerns
Parent|child problems

Communication problems
Running away
School problems
Problems making friends
Parental loss of control
Sibling problems
Blended family issues
Legal difficulties

Marital struggles/problems
Sexual or intimacy problems
Alcohol/drug problem (self)
Alcohol/drug problem (family)
Do you use tobacco?
Death of a loved one
Compulsive gambling
___ Attention Deficit Disorder or ADHD
Feelings of hopelessness
Too much anger in my life
Feelings of inadequacy
Loneliness
Upset for unknown reasons
Feelings of Isolation
Self-esteem problems
Sexual abuse (now/recent/in past)
Physical abuse (now/recent/in past)
Family violence (actual or potential)

Problems with parents
Problems handling stress
Not able to relax
Social Phobia
Stress related physical symptoms
Migraine Headaches
Ulcers
Medical condition effecting mood
Sleep problems (not enough)
Sleep problems (too much)
Sleep Apnea
Canabis use: how often?

OCD

Other
Other

(Please turn to page two on other side)

Medical History

A. Hospitalizations/Surgeries:

B. Serious Illness/Injuries:

C. Current Medical Condition:

D. Do you smoke cigarettes or drink? If so, how often?

E. Current Medications:

F. Physician's Name: /Phone _____

G. Date of last visit:

How do you imagine counseling could best help you and the important people in your life? If you have been in counseling before, what worked best and what would you want to change or happen this time? _____

Please provide any additional information that you think may be important or may be helpful.

Client's Signature Date

Guardian's Signature Date
If client is under 18

(7.13)

Counseling Center

Counselor Initial Assessment Disclosure Statement

It explains important financial, legal, and procedural information for clients

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Dear Clients,

Welcome to CAFY Counseling Center (CCC). We are pleased that you have chosen our services. In order to inform you about our policies, fees, and your counselor's background, we have provided the following information. The mission of CCC is to assist individuals in recovering from the effects of trauma caused by crime and violence through provision of psycho-educational, cognitive behavior and solutions focused therapy.

1. Everything discussed in counseling sessions is confidential. We do not release information without your written permission, except:
    a. When there is a threat or risk of self-harm (suicide), or harm to another person (homicide).
    b. When there is "reasonable cause" to suspect abuse or neglect of a child, disabled or elderly person, from anything reported in a counseling session.
    c. When we receive a subpoena issued from a judge or court.
    d. When a client describes sexual exploitation from a therapist.
2. Your counselor will assess for suicidal thoughts/ideation.
3. **Interns:** Part of the mission of CCC is to train professional clinicians. Your counselor may be an intern however, please be assured that s/he has received Master's level and above training and is presently under intensive supervision. Moreover, as a graduate student counseling intern working in the state of Maryland, they offer services that are aligned with the standards and practices of the Nation Board of Social Work Professional Counseling.
4. **The therapy** offered at Community Advocates for Family & Youth is comprehensive and seeks to meet the needs of all, regardless of multicultural, developmental and diverse factors.
5. **Counselors** vary in their approach to counseling. You have a right to choose who suits your needs. If you have concerns over the suitability of your counseling please discuss this with your counselor. If an understanding cannot be reached, s/he can help you arrange for an appropriate referral. If for any reason you want to file a concern or complaint, you have the right to Arleen Joell, who is the Executive Director of CAFY.
6. **Fees:** There are fees associated with CAFY Counseling Center. These Fees should have been discussed with you. If not please see the front desk or the billing manager before you leave. However, we make every effort not to turn away for services due to ability to pay.
7. **Appointments:** Counseling sessions are 50 minutes. Consistency in keeping appointments is important to the counseling process. If you are unable to keep an appointment, you must give 24 hours' notice or you are subject to be charged a $20 no show fee for any appointments not canceled ahead of time. A suspension of services if the client has three consecutive no shows.
8. **Length of time:** Most counseling sessions are 45-50 minutes in length. Sometimes reasons exist for deviating from that time frame. A maximum time of 4 months with a two month extension is initially offered. This required length of treatment is determined by the therapist and the client.
9. **Termination:** Termination is a part of the therapeutic process and is usually determined by the mutual agreement between the client and therapist. If at any point during therapy I assess that I am not effective in helping you reach your therapeutic goals or that you are not willing to follow through with suggestions or recommendations that I make, I will discuss with you as to whether or not continuing in treatment is the best option for you. If we determine that it is not best to continue, I will offer referrals that may be of help to you. If you choose to use one if the referrals and if you request and authorize in writing, I will talk to the therapist of your choice in order to help with the transition, If at any time you want another professionals opinion or wish to consult with another therapist, I will assist you with referrals, and if I have your written consent, I will provide that professional with essential information needed. Please know that you have the right to terminate therapy at any time.
10. Should the client ever see the counselor out in public, you will never approach them or say hello to them. This would compromise confidentiality (because someone may ask how you know each other). It is the client's choice if they want to say hello to the therapist (and then the therapist can say hello back once the contact is initiated by the client).
11. Ask if the client has questions about any of the above.

To be completed and signed during session with counselor. I understand the policies contained herein.

_____ _____

Client (Parent or legal guardian, if client is under 18) Date

_____ _____

Counseling Center

Counselor Initial Assessment Disclosure Statement

It explains important financial, legal, and procedural information for clients

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Client	Date	
Counselor	Date	Audited by

HIPAA Document –
Retain for Minimum of 6 years Effective Date: 11.11.12

Community Advocates for Family & Youth, Inc.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact CAFY; P. O. Box 4419; Capitol Heights, MD or 301-390-4092 or by email info@cafyonline.org.

WHO MUST FOLLOW THIS NOTICE: This notice describes the privacy practices of the Community Advocates for Family & Youth, Inc. Counseling Center. OUR OBLIGATIONS:

Law to requires us:
• Maintain the privacy of protected health information;
• Give you this notice of our legal duties and privacy practices regarding health information about you; and
• Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following categories describe ways that we may use and disclose health information that identifies you ("Health Information"). Some of the categories include examples, but every type of use or disclosure of Health Information in a category is not listed. Except for the purposes described below, we will use and disclose Health Information only with your written permission. If you give us permission to use or disclose Health Information for a purpose not discussed in this notice, you may revoke that permission, in writing, at
any time by contacting the Center's Privacy Official.

- **For Treatment.** We may use Health Information to treat you or provide you with health care services. We may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our facility who may be involved in your medical care. For example, we may tell your primary physician about the care we provided you or give Health Information to a specialist to provide you with additional services.
- **For Payment**. We may use and disclose Health Information so that we or others may bill or receive payment from you, an insurance company or a third party for the Page 2 of 5 treatment and services you received. For example, we may give your health plan information about your treatment so that they will pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations**. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use Health Information to review the treatment and services we provide to ensure that the care you receive is of the highest quality.
- **Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services**. We may use and disclose Health Information to contact you as a reminder that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
- **Fundraising Activities.** We may use Health Information to contact you in an effort to raise money. We may disclose Health Information to a related foundation or to our business associate so that they may contact you to raise money for us.
- **Individuals Involved in Your Care or Payment for Your Care**. We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL CIRCUMSTANCES

- **As Required by Law**. We will disclose Health Information when required to do so by international, federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **Public Health Risks**. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of the hospital in certain limited circumstances concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; however, we will only release this information if you agree or when we are required or authorized by law.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we maydisclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

YOUR RIGHTS:

You have the following rights regarding Health Information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. To inspect and copy this Health Information, you must make your request, in writing, to the CAFY Counseling Center Privacy Official.
- **Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request, in writing, to the CAFY Counseling Center Privacy Official.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures of Health Information we made. To request an accounting of disclosures, you must make your request, in writing, to the CAFY Counseling Center Privacy Official.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. In addition, you have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about your surgery with your spouse. To request a restriction, you must make your request, in writing, to the CAFY Counseling Center Privacy Official. We are not required to agree to your request. If we agree, we will comply with your request unless we need to use the information in certain emergency treatment situations.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to the CAFY Counseling Center Privacy Official. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current notice at the hospital. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the CAFY Counseling Center Privacy Official. All complaints must be made in writing. You will not be penalized for filing a complaint.

Notice of Privacy Practices Acknowledgement of Receipt

NAME:

DOB:

DATE:

The CAFY Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy, we have provided you, copies of the current notice are available by requested a copy at the Center.

I acknowledge that I have received the Notice of Privacy Practice.

Signature of Patient or Client Representative DATE

Print Name Relationship to Client

If written acknowledgement is not obtained, please check reason:

Notice of Privacy Practices Given – patient unable to sign _____

Notice of Privacy Practices Given – patient declined to sign _____

Signature of CAFY Representative Date

LETTER OF AGREEMENT
ADULT CLIENTS IN INDIVIDUAL PSYCHOTHERAPY

Welcome. We hope your time here is worthwhile. We are giving you this letter to assist in answering any questions you may have about psychotherapy/counseling. It will also explain the administrative procedures of CAFY Counseling Center. Please go over this letter carefully and feel free to show it to other professionals you trust or to family members if you wish.

At the end of this letter is a place for you to sign your name; doing so, means that you have read and understand all the points in this letter.

OUR SENSE OF WELL-BEING is influenced by many interrelating factors. You are here to address non-medical factors. If you have not had a recent physical exam, we recommend that you get one from your doctor as soon as possible. This is important because we want to make a clear distinction and understand any connections between medical and psychological factors affecting your well-being. Since none of our clinicians are physicians, they cannot know if you have a medical condition/(s) that might be related to our work. Please let us know about any medical health problems you have.

EACH OF OUR APPOINTMENTS is scheduled to last 50 minutes. We are usually very prompt. If your clinician is ever late, we try to let you know in advance, even if the delay is just a few minutes. If we cause a late start and you can stay longer, we will still see you for a full 50 minutes. If you arrive late for an appointment, we may still need to end the meeting 50 minutes after it was scheduled to begin.

BETWEEN MEETINGS you may leave messages for your clinician at 301-882-1000. If you need to speak with them right away, please leave a brief message at our office. If your need is urgent please let the office know that your call is urgent. If your clinician unavailable, someone will call you. They may also talk with you about some emergency numbers you can call if you feel you are in crisis. When compared with other forms of seeking help, outpatient counseling is fairly non-intensive in that meetings usually occur once a week or less. If you feel that this is not enough for you at this time, we can discuss alternatives that provide increased therapeutic support.

HOW MANY SESSIONS WILL I BE ATTENDING? is a question you may be thinking about. At the beginning of therapy, we can choose how many sessions you want to meet for. Our Center is crisis focused so length of time is usually 4-6 months. However, the length of time will be discussed and determined between you and your clinician. If you choose to stop sessions, it is recommended that we discuss this during at least one more session. Achieving clarity about the reasons for discontinuing, talking about what the experience was like, and making plans are important steps. We might decide to stop because your goals have been reached. Or we might decide that you are not going to reach all of your goals at this time. You are free to resume sessions in the future if/when there are openings in our office.

THE FEE for individual psychotherapy is $85.00 per session. Everyone is expected to pay the $25.00 co-payment for their initial visit. If your insurance is of the "managed care" type, the ongoing fee is decided by a contract between the Center and your insurance company and you will probably have a co-pay. For those individuals without insurance coverage or insurance we do not accept we offer a *sliding scale* based on financial need. You may pay by credit card, cash or check. You will get a receipt. There is a $25.00 fee for returned checks. If a check is

returned a second time, you will be asked to pay subsequent balances by credit card, cash or by money order. Please note: Cancellations less than **48 hours** (unless there are extenuating circumstances such as illness or unsafe driving conditions) or missed appointments, will be charged for at a rate of $45.00 (*We cannot bill your insurance company for a missed session.*). You will not be charged for a session if you let us know at least 48 hours in advance.

Please let us know if there is any change in your insurance policy. If there is a change or loss of coverage and you do not tell me, or if your insurance company goes out of business or refuses to pay a valid claim, you will become responsible for the insurance balance.

ETHICS AND CONFIDENTIALITY are essential to the success of psychotherapy/counseling. With a few exceptions everything we discuss is kept in strict confidence. Normally, information about our sessions is released only upon written permission from you. There is a special form for this that requires both our signatures.

Maryland law requires or allows confidentiality to be overturned even when a release is not signed when: 1) Someone is at risk for suicidal or homicidal behavior; 2) When it is suspected or known that a child or elder person is being abused or neglected; 3) When the person receiving services or the legal guardian responsible for payment refuses to pay for services rendered; 4) When a judge court orders information from a patient's file; 5) You will also be given a copy of the HIPPA act which went into effect in April 2003. It explains privacy and confidentiality in more detail.

BY SIGNING BELOW you acknowledge that you have read this communication or have had it read to you. You may ask for a copy of this agreement or access it at ww.cafycounseling.com. You further acknowledge your right to ask questions if you do not understand this communication. We see psychotherapy/counseling as an effort by both therapist and client to work toward improving the quality of the client's life and look forward to working with you.

_/ _____/_____
Client Signature Date

_/ _____/_____
CAFY Representative Signature Date

(1111)

CAFY Counseling and Family Center
LETTER OF AGREEMENT FOR PARENTS/GUARDIANS

Hello, CAFY Counseling and Family Center's policy is to give everyone a letter of agreement. Your son or daughter, or child who you are guardian for will also be given a letter. Our purpose here is to elaborate on what helps make counseling a successful experience for teenagers. This will also include administrative matters that you need to know about.

THE ADOLESCENT YEARS are often a difficult and challenging part of our lives add any kind of trauma and the difficulty goes higher. Still, in many ways, being a child or an adult in our society is easier because the roles for these age groups are more clearly defined. Teenagers are getting ready for adulthood but they are not quite there. It is not surprising that these are often trying times for parents, as well.

Children/Teenagers SEE SOMEONE LIKE US FOR A VARIETY OF REASONS. Some are brought by concerned parents and find that they like talking to a counselor. Others ask to go because they know they have things they need to talk about. Sometimes teenagers are made to go to counseling. It is hardest for someone who is told that she or he must go because then they see counseling as an extension of the control they feel that others have over them. Yet, if a teenager's life is out of control, counseling will give him or her the *opportunity* to gain perspective and get back on course.

CHILDREN NEED TO FEEL THAT COUNSELING IS NOT FOR THEIR PARENTS OR SOMEONE ELSE. In order for counseling to be successful it must not be seen as a punishment. To help teens understand this, we tell them that whatever they say to me stays between us. Of course there are exceptions to this rule. *Maryland law requires or allows confidentiality to be overturned even when a release is not signed when: 1) Someone is at risk for suicidal or homicidal behavior; 2) When it is suspected or known that a child or elder person is being or neglected; 3) When the person receiving services or the legal guardian responsible for payment refuses to pay for services rendered; 4) When a judge court orders information from a patient's file; 5) You will also be given a copy of the HIPPA act which went into effect in April 2003.* It explains privacy and confidentiality in more detail.

Although we will respect your child's desire for confidentiality, our hopes are that your teen will choose to share more of his or her feelings with you. Of course, you are free, to convey to the clinician any information you feel that you should have.

OUR SENSE OF WEL-BEING is affected by many factors. Your child is here to address non-medical favors. We recommend that your child have a physical examination if she or he has not had one recently. This is important because we want to make sure that none of the problems discussed are the result of physical health difficulties. Since our clinicians are physicians, they cannot know if your child has a physical condition(s) that might be related to the reasons she or he has to come to CAFY.

THE FEE for individual psychotherapy is $85.00. Everyone is expected to the pay the $25.00 co-payment for their initial visit. Usually, parents pay the fee for their children. In situations

where your child has a

source of income, you can work out payment arrangements that address everyone's needs. For those with insurance, that we accept, the fee is arranged between CAFY Counseling and your insurance company and your fee will be the co-pay you may have. For those without insurance we do not participate we offer a ***sliding scale.*** Please ask about the sliding scale if the fee presents a problem. You may pay by cash, credit card, or check. There is a $25.00 fee for returned checks. If a check is returned a second time, you will be asked to pay for the balance you owe in cash or by money order.

Please let us know if there is any change in your insurance policy. If there is a change or loss of coverage and you do not tell us, or if your insurance company goes out of business or refuses to pay a valid claim, you will become responsible for the insurance balance.

APPOINTMENTS are scheduled to last 50 minutes. Cancellations less than 48 hours (unless there are extenuating circumstances such as illness or unsafe driving conditions) or missed appointments, will be charged a rate of $45.00 (*we cannot bill your insurance company for a missed session.)* If your teen is dependent on you for transportation, *please return five minutes before the appointment is scheduled to end.*

Between meetings please call 301-882-1000 for questions or cancellations. If you need to speak with your clinician right away, call 301-882-1000, or leave that on the message. Messages will get emailed to your therapist immediately and they will contact you as soon as possible. If your clinician is away on vacation or professional meetings, we will have someone else call you.

BY SIGNING BELOW you acknowledge that you have read this communication or have had it read to you. You may ask for a copy of this agreement or access it at www.cafycounseling.com. You further acknowledge your right to ask questions if you do not understand this communication. We see psychotherapy/counseling as an effort by both therapist and client to work toward improving the quality of the client's life.

_____
Child and Parent Name

_____
_____
Parent Signature
Date

_____
_____
CAFY Representative Signature

Counseling & Family Center NO-SHOW POLICY

Each time a client misses an appointment without providing proper notice, another client is prevented from receiving mental health support and care. Therefore, CAFY Counseling & Family Center reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice or at the time of your confirmation call.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid upon arrival of your next appointment. Multiple "no shows" will result in person being placed at the bottom of the waiting list and/or may result in termination from our mental health services.

No-Shows interfere with our patients' ability to benefit from counseling services. By initialing each line, you are agreeing to CAFY's Counseling and Family Center's no-show policies.

1. _____ If client fails to show for 2 appointments, client will be placed on waitlist.

2. _____ Clients are considered no-shows if they cancel within 24 hours or fail to cancel during their confirmation call.

4. _____ Courtesy voicemails will be left when client is not available, that is considered confirmation or the appointment. It is the client's responsibility to call the office to cancel within 24 hours.

3. _____ Returning clients cannot be late to their appointments more than 3 times.

4. _____ New clients cannot be more than 15 minutes late to their initial intake; 16 minutes late is considered a no show and client cannot be seen.

5. _____ Clients will be considered no-shows if they decide to leave during Appointment.

6. _____ Minor must arrive with a parent/legal guardian & have appropriate guardianship Paperwork.

PLEASE NOTE: We do make routine appointment reminder calls. All reminder calls are strictly as a courtesy and it is the patient's responsibility to remember their appointment date and time

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Print Client
Name_____

Print Parent/Legal Guardian
Name_____

Signatures Please:

Signature of
client_____Date_____/_____/_____

Parent/Legal Guardian Signature of Client

_____Date_____/_____/_____

Parent/Legal Guardian Witness Signature

_____Date_____/_____/_____