CLIENT INFORMATION

Name of Client (please print) ____

Address ____
City State Zip

D.O.B.______________________ Birth Sex: M or F (circle one) Marital Status ________ (single, married, divorced, widowed)

Gender Identity:____________________

Race: *(circle most predominate)* Hispanic or Latino, American Indian or Alaskan Native, Black or African American, Asian, Native Hawaiian or other Pacific Islander, White

Email Address:____

Primary Language: ____

Employment: *(where and what do you do)*____

____

Home Phone:______________________ May we leave a message? ☐ Yes ☐ No

Cell Phone:______________________ May we leave a message? ☐ Yes ☐ No
(Cell number may be used for Telehealth/Zoom so please write legibly)

Work Phone:______________________ May we leave a message? ☐ Yes ☐ No

What is your religious affiliation? ____

What is your highest level of schooling? ____

Are you currently on probation/parole? Y___N____

CONVICTION(S)	DATE ARREST OCCURRED	WAS PROBATION/ PAROLE SUCCESSFULLY COMPLETED	DATES INCARCERATED (IF APPLICABLE)

Who is your parole/probation officer:____

Please describe the most recent legal issues you have had (even if you are not on probation):________________

____

Why are you here today? *(circle all that apply)*

Counseling with Licensed Clinician *(length to be determined)*

Assessment *(one appt. with counselor for recommendations)*

Anger Management Class *(8 weeks to complete)*

Domestic Violence Offender Treatment Intervention Class *(52 weeks to complete)*

Parenting Class *(9 weeks to complete)*

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EMERGENCY CONTACT INFORMATION

Name ______________________________ Phone # ______________________

Relationship to you ____

Choose # 1 or # 2

1. I give consent for LSLC to contact this person only in case of a *medical emergency*________.
(initial)

OR

2. I give consent for LSLC to speak to this person about any information in regards to my care or services ________.
(initial)

*The consent to contact this person is valid for **one year** or until I notify LSLC to revoke it________.*
(initial)

I acknowledge that the above information is correct and that my confidentiality is protected.

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Life Skills Staff Date

****

Client revoked consent on: ______________________ LSLC Staff: ______________________

CLIENT RIGHTS FOR SERVICES

As a client, you have the right to appropriate care and protections. State and Federal laws and regulations guard your confidentiality. You may also have other rights, which are listed below. Read carefully and be sure to ask your facilitator if you have any questions about them.

1. Confidentiality and Release of Information: I understand that information concerning my contact with this agency will be held confidential among the LSLC staff to protect my right to privacy. I further understand that such information will not be disclosed without my written permission, or that of my legal guardian, except under special circumstances such as:

   a. If I threaten to injure myself or someone else
   b. When such information is required by law to be reported such as information regarding abuse, neglect, molestation, or exploitation of minor, incapacitated adult, elder person 65 or older, or in case of court order
   c. For medical emergency

2. I understand and have the right to:
   a. Privacy
   b. Considerate care that respects my privacy and individual needs
   c. Information about my services and any correspondence related to me
   d. Know the names and functions of everyone who works with me
   e. Refuse a recommended plan of care
   f. Expect staff to treat all communications and records about my care confidentially
   g. Expect continuity of care and be told about choices
   h. Appropriate recognition and consideration of my spiritual and cultural values

3. I understand I have the right to file a complaint about the services I receive if necessary. Misunderstandings or conflicts may arise and it is my right to have these issues resolved. LSLC has established a Grievance Policy that will investigate my complaint and form a plan for corrective action.

A written copy of the *Privacy Notice to Patients* and *Grievance Policy* will be provided to me upon request.

Having been informed of my rights and obligations as a client, I hereby give my consent for services:

____________________________ ____________________

Client Signature or Guardian | Date

LSLC Staff | Date

1. How many child(ren) do you have?____________________

    ____________Male(s)   ____________ Female(s)

2. What are the ages of your child(ren)?____________________

3. Do your child(ren) live with you?____________________

4. If they do not live with you, who do they live with?____________________

5. Are you on good terms with the other parent?____________________

6. Do you make decisions together concerning your child(ren)?____________________

7. What areas are currently a problem for you and your family? Please check all that apply.

Yes ___	No ___	1. Money
Yes ___	No ___	2. Housing
Yes ___	No ___	3. Transportation
Yes ___	No ___	4. Child care
Yes ___	No ___	5. Health care
Yes ___	No ___	6. Employment
Yes ___	No ___	7. Problems in the neighborhood
Yes ___	No ___	8. Legal problems
Yes ___	No ___	9. Relationships with other family members (in- laws, extended family)
Yes ___	No ___	10. Relationships with friends
Yes ___	No ___	11. Problems with running a household (laundry, groceries, cooking, cleaning, other)
Yes ___	No ___	12. Mental health problems
Yes ___	No ___	13. Problems with school
Yes ___	No ___	14. Problems with drugs and alcohol
Yes ___	No ___	15. Other problems ____________

8. Please describe what you hope to achieve by attending this class____________________

    ____

________________________   ________________________
Signature   Date

1200 N. Thornton St., Suite H Clovis, NM 88101
Ph. 575-935-4411/Fax 575-935-0400

RELEASE OF INFORMATION

Client Name (Print) ______________________________ DOB ______________

Address ____
Street City State Zip

I hereby authorize (Agency Name) ______________________________

Attention (Name & Title) ______________________________

Phone Number ______________________ Fax Number ______________________

To release the following information for the purpose of coordination of care & treatment planning:

- Intake Information
- Discharge Summary or Certificate of Completion
- Psychiatric/Psychological Evaluation
- Treatment Plan(s)
- Recommendation Letter
- School Records (report cards, discipline, teacher observations, IEP)
- Diagnosis, Functional status, Prognosis
- Medical Records from ________ to ________
- Legal Records (excludes attorney/client privilege)
- Psychosocial Assessment
- Domestic Violence/Anger Assessment
- Placement History
- Substance Abuse/Alcohol Assessment (protected under 42 CFR Part 2)
- Chronological Offense Records
- Probation/Parole Agreement
- Court Orders
- Consultation/Dialogue (phone, in-person, secure email, fax)
- Referral Information/Service Plan
- Fees/Balance Owed
- Educational Tests/Evaluations
- Attendance/Progress Reports
- Other ______________________

******MH/BH Psychotherapy Notes (actual notes excluded as defined in 45 CFR 164.501)

The information shall be released to (Agency Name) ______________________________

Attention (Name & Title) ______________________________

Phone Number ______________________ Fax Number ______________________

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PROHIBITION ON REDISCLOSURE: Federal Law & State Regulations prohibit further disclosure of this information to any Persons or Agency without securing another proper written authorization for that purpose.

This is valid for one (1) year after the date of this signature or until either party terminates in writing. I expressly understand and agree that no legal responsibility or liability of any nature shall be to the respondent, the agency or its employees in acting upon this authorization and request.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Parent/Legal Guardian (if applicable) Date

______________________________ ______________________
Signature of Life Skills Staff (Witness) Date

FINANCIAL AGREEMENT
PARENTING CLASS
SELF-PAY

+++++ *IMPORTANT* +++++

The Parenting Program is comprised of Eight classes. LSLC uses the *Active Parenting* curriculum which is a video-based parenting program. It combines videos, reading and group discussion. It is based on theories that stress the importance of mutual respect between people, with an emphasis on cognitive-behavioral approaches that help people make positive changes. It includes methods such as natural and logical consequences, recognizing the goals of behavior, family meetings and problem-solving skills as well as the importance of encouragement.

The Parenting Program is $160 ($20 per class x 8 classes). You are allowed to pay weekly if you are unable to pay the full balance. We accept cash or money order. You can pay the facilitator in class or come into the Life Skills Office during business hours – Monday-Thursday 8:30 am-5:00 pm.

If you miss more than TWO classes, you will be dropped from the roster and have to wait for the next class. You will also forfeit any monies paid and will have to pay the full balance in the next class.

Your facilitator will arrange any make-up classes.

If you miss a scheduled make-up class, you will automatically be dropped.

You will need to complete ALL eight classes and pay in full before we can issue a completion certificate.

I agree to pay $160 for the Parenting Program and attend regularly.

I declare that I have read the above information and understand what I have read.

______________________________ ______________
Client Signature **Date**

______________________________ ______________
Life Skills Staff **Date**

FINANCIAL AGREEMENT - CONSENT FOR RELEASE OF INFORMATION
THIRD-PARTY PAYER

****Only for Clients Whose Services are Paid for by Another Agency***

Client Name:____

I have been referred to Life Skills Learning Center for: *(circle all that apply)*

Counseling with Licensed Clinician *(length to be determined)*
Therapy Intake/Appointment - $160.00
Therapy Session/Appointment - $130.00

Assessment *(1 appointment with licensed counselor for recommendations)*
Counseling Recommendation/Evaluation - $75.00

**Anger Management Class *(8 weeks to complete)*
Class $20.00 each – total $160.00

**Parenting Class *(8 weeks to complete)*
Class $20.00 each – total $160.00

**Life Skills Class *(16 weeks to complete)*
Materials/Workbook - $45.00 (one-time fee)
Class $25.00 each – total $400.00

**IF I AM REQUIRED TO MAKE UP A CLASS, I WILL BE RESPONSIBLE FOR ALL FEES OUT OF POCKET (see amounts above).

I agree________________________________will be billed to cover the cost of my services. I will strive to make all of the classes and/or appointments I am required to attend. If I fail to attend as instructed, I may be dropped and the referring agency/third-party payer will be notified. This agreement will remain in effect while I am a client at LSLC.

Release of Confidential Information

I also consent for LSLC to disclose to ______________________________the following information: Full name and number of classes/appointments attended. This disclosure of Personal Health Information is used for the sole purpose of billing.

I understand I may request a copy of this agreement.

Client Signature or Guardian:______________________________ **Date:**____________

LSLC Staff:______________________________________ **Date:**____________