L·S·L·C
Life Skills Learning Center

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)*

****

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: _____

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CLIENT RIGHTS FOR SERVICES

As a client, you have the right to:

- Select a professional counselor who meets your needs.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Obtain a copy of the code(s) of ethics your counselor must follow.
- Receive a written explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice (e.g., career development, adolescents, couples, etc.).
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor in the event of a crisis).
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals.
- Understand the implications of diagnosis and the intended use of psychological reports.
- Obtain copies of records and reports.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

CLIENT RESPONSIBILITIES

In order for your counselor to provide the highest quality of services, it is important that clients:

- Adhere to established schedules. If you must miss an appointment, contact LSLC as soon as possible.

- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in sessions.
- Inform your professional counselor of your progress and challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor if you are receiving mental health services from another professional.
- Consider appropriate referrals from your counselor.
- Avoid placing your counselor in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.

WHAT TO DO IF YOU ARE DISSATISFIED

Remember that a counselor who meets the needs of one person may not meet the needs of another. If you are dissatisfied with the services of your counselor:

- Express concerns directly to the counselor, if possible.
- Seek the advice of the counselor's supervisor if the counselor is practicing in a setting where he or she receives direct supervision.
- Terminate the counseling relationship if the situation remains unresolved. Notify the Program Manager or Executive Director of your issue.
- Contact the appropriate state licensing board, national certification organization, or professional association if you believe the counselor's conduct to be unethical.

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

_____ _____

Client Signature or Guardian Date

_____ _____

LSLC Staff Date

Please inform staff if you would like a copy of these rights and responsibilities. A written copy of the full *Privacy Notice to Patients* and *Grievance Policy* can be provided upon request.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* 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 _____

A2663B 10-04-2005

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult 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

When did the symptoms begin? _____

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MENTAL HEALTH/BEHAVIORAL HEALTH CLIENTS
(All Answers Are Completely Confidential)

Would you like a text reminder for upcoming appointments? (only for cell numbers) ☐ Yes ☐ No

1. Please report your current emotional state: *(circle)*

   Depressed Suicidal Angry Agitated Hopeless Stressed

   Other_____

2. Have you had any previous suicide attempts? ☐ Yes ☐ No

   The date(s) of the most recent attempt: _____

3. Do you have someone you can safely talk to about anything? ☐ Yes ☐ No

4. Do you smoke? ☐ Yes ☐ No

5. Do you drink alcohol? ☐ Yes ☐ No

6. Do you use illegal drugs? ☐ Yes ☐ No Which one(s)?_____

   _____

7. If you answered **yes** to **Question 4, 5 or 6** do you struggle with dependency/addiction?

   ☐ Yes ☐ No

8. Are you currently enrolled in mental health services with a licensed counselor ***at another agency***? ☐ Yes ☐ No If so, who with? (Agency and/or Counselor's Name)_____

   _____

9. Please identify ALL medications (prescription or over-the-counter) you are currently taking:

MEDICATIONS	DOSAGE/TIMES DAILY	USED FOR

10. Have you ever suffered a head or brain injury?_____ If so, please provide a date that it occurred and the circumstances:_____

_____

11. What are the thoughts, feelings or behaviors that have been troubling you?_____

_____

12. Do you have any mental health/behavior health issues in your family?_____

_____

13. Do you have any trouble carrying out daily living activities such as eating, dressing, shopping?_____

I understand if I miss three (3) appointments in a row or I am continually a *No-Show*, I may be discharged from care_____.
(initial)

If at any time my clinician determines I am aggressive, threatening or presenting a safety issue, he/she may terminate my services at will_____.
(initial)

_____ _____

Client or Guardian Signature Date

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Life Skills Learning Center

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:

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

****

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

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Life Skills Learning Center

Life Skills Learning Center phone: 575-935-4411 Fax: 575-935-0400

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Insurance companies require the client to complete the PCP Release form

To authorize release of information to physicians, other than my PCP, please complete a general release form: 'Consent for Release'

Name of Client (last, first, MI)	Client's Social Security Number	Client's Date of Birth

1. Please check one of the following:

- ☐ NO, I DO NOT give consent to release information to my Primary Care Physician ***(Please skip to section 3)***
- ☐ YES, I DO give consent to release information to my Primary Care Physician (PCP) named below *(If you check yes the Counselor will communicate with the named physician and/or send treatment plan and/or progress notes of therapy as agreed upon by the client and Counselor.)*

2. If you checked YES, please complete the following:

I hereby give my informed consent for Life Skills Learning Center to:

(check all that apply)

- ☐ Talk with Physician
- ☐ Release written documentation regarding my treatment to

Primary Care Physcian _____

Address _____

Phone (___) ___-_____ Fax (___) ___-_____

3. Client Authorization: I understand

- This authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization.
- My refusal to release records will not affect my ability to obtain treatment.
- If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed.

Signature of Client (Or responsible Party if Client is a Minor)	Date
Printed Name (last, first, MI)	Relationship to Client

Witnessed by: LSLC staff _____ Date _____

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Telehealth Informed Consent Form

I **(print name)** _____ consent to engaging in telehealth with Life Skills Learning Center as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning and therapy. Telehealth will occur primarily through Interactive audio, video, telephone and/or audio/video communications.

I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entitles shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Life Skills Learning Center that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my counselor believes I would be bettered served by other interventions I will be referred to a mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my counselor, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of ZOOM video-conferencing is HIPPA compliant, but that may have issues with Wi-Fi connectivity. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my counselor, and all of my questions regarding the above matters have been answered to my approval.

6) I understand If I chose to utilize Life Skills Learning Center homebased telehealth services, continuation of this service is at the discretion of the counselor in that it is conducive to the delivery of value-added, quality, up to 60 minute sessions. Factors that influence the success and continued delivery of homebased telehealth services include, but are not limited to: level of distractions within my home, my internet connectivity (dependability/speed) and my equipment (charged phone, computer, microphone/ camera quality). I understand my counselor will determine if he/she believes I would be better served by accessing services through the main office, and will discuss this with me as deemed necessary.

I further understand that I must be PHYSICALLY PRESENT within the state of NEW MEXICO to engage in telehealth services with Life Skills Learning Center.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, I am in a life threating or emergency situation, and/or I am abusing drugs or alcohol and am not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

_____ _____

Client Signature or Guardian Date

_____ _____

LSLC Staff Date

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FINANCIAL AGREEMENT

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

FILING INSURANCE

Client Name:_____

If I have insurance coverage with a Managed Care Organization that Life Skills Learning Center is ***credentialed with***, **I authorize LCLS to release personal health information (PHI) contained in my client record and to complete claims on my behalf.**

The information authorized to be released shall include, but is not limited to, demographic information, behavioral health history, diagnosis or treatment, progress notes and/or information about drug or alcohol abuse. I waive any privilege pertaining to such confidential information. Life Skills Learning Center, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. This agreement will remain in effect while I am a client at LSLC.

I also understand (if applicable), I am responsible for any co-pays and/or *deductibles. I will pay at the time services are rendered unless other arrangements have been made. If unpaid co-pays/deductibles become excessive, LSLC reserves the right to refuse service until such time payment is made. If I lose my insurance coverage or change carriers, I am responsible for notifying LSLC.

If your insurance deductible has not been met, you will be required to pay an estimate of $75.00 before services begin. When the claim is filed you will be notified of the difference.

I understand I may request a copy of this agreement.

Insurance Co._____ **Member #**_____

Client Signature or Guardian:_____ **Date:**_____

LSLC Staff:_____ **Date:**_____

National Strategy for Suicide Prevention (NSSP)

"Embedding Suicide Screening in a Holistic, Recovery Oriented System of Care"

Suicidal? In Crisis? Need Help NOW?

- Call 9-1-1 or go to the local hospital Emergency Room
- National Lifeline: 1-800- SUICIDE (1-800-784-2433)
- The New Mexico Crisis and Access Line (NMCAL): 1-855-NMCRISIS (1-855-662-7474)
- Veteran's Crisis Line: 1-800-273-8255 (Press 1)
- LGBT Youth Suicide Hotline: 1-866-4-U-TREVOR
- Agora Crisis Center: 1-866-HELP-1-NM (505-277-3013)
- CrisisTEXT LINE: Text "GO" to 741-741

Other Important Numbers

- Statewide Child Abuse Hotline: 855-333-SAFE (7233) or #SAFE from a cell phone
- New Mexico Domestic Violence Hotline: 1-800-773-3645 (Statewide)
- New Mexico Poison Information Center: 1-800-432-6866
- Runaway/Suicide Adolescent Hotline (National Switchboard): 1-800-621-4000

"There are a thousand reasons to live this life, everyone of them sufficient"

- Marilynne Robinson

In collaboration with New Mexico Behavioral Health Services Division (NM BHSD) and funding by a grant from Substance Abuse and Mental Health Services Administration (SAMHSA)

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INFORMATION

CRISIS CARD

I (print name)_____, acknowledge I have received the ***Crisis Card*** with emergency numbers for after-hours care. If I require information about additional resources, they will be provided to me upon request.

_____ _____

Client Signature or Guardian Date

NO-SHOW FEES AND CANCELATIONS

If I (print name) _____, cannot attend my scheduled appointment with Life Skills Learning Center and DO NOT call to reschedule or cancel at least 24 hours in advance, I understand LSLC has the right to charge me for a no-show fee.

The first missed appointment will be a warning and I will not be charged the fee. If I miss two appointments, I agree to pay the $25.00 "no-show" fee. If I miss three appointments, I agree I will pay the required fees ($50.00 total) *BEFORE* I can return for another appointment. If I fail to pay, I understand I could be dropped as a client.

This fee is my responsibility and my insurance will not be charged.

I am also not allowed to have excessive cancelations. The clinician's time is valuable and I cannot repeatedly cancel my appointments. I understand it is at my clinician's discretion what qualifies as "excessive" and I will be notified if I can continue to schedule or I will be dropped as a client.

If I am ordered to attend counseling, the referring agency or my probation officer will be notified of ALL no-shows and cancelations.

_____ _____

Client Signature or Guardian Date

*LSLC takes cash, money orders and credit cards over the phone.

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We at Life Skills Learning Center are dedicated to empowering our clients in a place of new possibilities through a process of healing and growing within a supportive and compassionate environment. As a part of LSLC's efforts to ensure that quality of care is provided to all of our clients, we encourage clinical interns to observe sessions by licensed therapists as a part of their internship experiences. Clinical Interns are graduate level students in the fields of Counseling and Social Work from a university who are required to intern in different clinical components of their field of education. Interns are directly supervised by a Licensed Mental Health Counselor or Licensed Clinical Social Worker who is board certified in the state of New Mexico. With this, we would like to know your comfort level in allowing a student intern in either the field of Counseling or Social Work to sit in, observe and/or participate in your counseling sessions. Please initial all you are willing to allow regarding a student intern.

I hereby submit my consent to LSLC for:

____ A clinical intern to sit in and observe my sessions with a licensed therapist;

____ A licensed therapist to sit in and observe the work of a clinical intern for the purpose of clinical supervision an improvement in the intern's skill level

I hereby DO NOT submit my consent to LSLC for:

____ A clinical intern to sit in and observe my sessions with a licensed therapist;

____ A licensed therapist to sit in and observe the work of a clinical intern for the purpose of clinical supervision an improvement in the intern's skill level

AGREEMENT:

I understand that if I agree to the above, the information discussed in my therapeutic sessions will only be discussed within LSLC for training purposes and as according to HIPAA standards and practices. I understand that I may revoke this authorization in writing at any time for any reason. In the event that I decide to rescind this agreement I will inform my therapist and/or office staff for the requested changes to take place. By signing below, I acknowledge that I have read, understand, and agree to everything in this agreement and am hereby consenting to the above.

Further, if the client is a minor child, I acknowledge, represent and warrant that I have legal right to agree to the procedures indicated on behalf of the named child below.

_____ _____ _____

Client Name Client/Guardian Signature Date

_____ _____

LSLC Representative Date