Therapist:______________
Date:_______________start/stop time_________
Case #:__________

ASSOCIATED COUNSELING PROFESSIONALS
2255 South 132nd Street, Suite 200, Omaha, NE 68144
PH: (402)334-1122 FAX: (402)334-8171
www.acpcounseling.com

Client Information

DEMOGRAPHICS		COMMUNICATIONS	
First Name		Home Phone	
Last Name		Work Phone	
Address		Cell Phone	
City/State/Zip		E-Mail Address	
Birth Date/age	date:___/__/_____ - age:______	OK to leave message at:	Home ___ Work____ Cell_____
Gender: _____Male _____Female		**DO NOT LEAVE MESSAGE _____ [please initial]** Appointment Reminders OK: phone or text **[circle choice]**	
Social Security Number: - -			
Marital Status [please circle]: Married - Single - Partnered - Separated - Widowed - Divorced			
Last Year (grade) School Completed:______ Highest Degree:		Emergency Contact Name: Phone #:	

EMPLOYER, FAMILY AND REFERRAL RELATIONSHIPS			
Employer/School		Occupation/Position	
Partner's Name:		Partner's birthdate/age:	
Who else lives in your home?			
Children, Siblings, or Other Relatives:			
Name	Age	Relationship	
Name	Age	Relationship	
Name	Age	Relationship	
My doctor's name:	Referred By: ___EAP ___Yellow Pages ___Insurance ___Another Therapist ___Friend ___Internet ___Minister/Priest/Rabbi ___Court ___School ___Work ___Family ___Other: ______________		
May we thank the referral source? _____Yes _____No -- If yes, please ask your therapist for a release form.			

BACKGROUND INFORMATION	
Please check all areas of concern:	___Suicidal Feelings ___Anxiety ___Children ___Marriage ___School ___Drugs/Alcohol ___Financial ___Depression ___Physical/Sexual Abuse ___Stress ___Parents ___Family ___Work ___Medical ___Sexual _____Legal
What is the primary reason for seeking counseling at this time?	
Previous mental health services? (counseling, psychiatrist, hospital?) Y / N Describe:	
List current medications (If you have a list, we can copy it.)	

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Billing Information

RESPONSIBLE PARTY (If Other Than Client)			
First Name		Home Phone	
Last Name		Work Phone	
Address		Cell Phone	
City/State/Zip		E-Mail:	
Birth Date		SS#: - -	
Gender	____Male ____Female		
Relationship to Client	____Parent ____Spouse ___Other ____________		
Employer/Company Name			
INSURANCE COMPANY INFORMATION or EAP Program Information (IF APPLICABLE)			
Who is the policy holder?	____Client ____Responsible Party (named above)		
Under employer's health plan?	____Yes ____No		
Identification Number or EAP Plan Name:		Plan/Group Number or EAP authorization #	
Address to send claims:		800 number to call for benefits or claims:	
Please present the policy holder's insurance card to our staff for copying			

Policy Holder's Authorizations

I authorize Release of Information by Associated Counseling Professionals to my insurance company.

______________________________ ______________________________
Signature **Date**

I authorize my insurance benefits to be paid directly to Associated Counseling Professionals for services rendered by therapists involved in my treatment, and I agree that I am financially responsible for all charges not covered by insurance.

______________________________ ______________________________
Signature **Date**

Therapist: ____________________ DSM/ICD-10 Code: ____________ Account #: ____________

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Welcome to Associated Counseling Professionals

Please take a few minutes to review the following office policies and procedures:

Appointments
Clients meet with our therapists by appointment only. You and your therapist will work out the frequency of sessions. Each session is reserved exclusively for you. If you need to cancel an appointment, please give at least a 24-hour notice. Late cancellations or 'no-shows' may be charged a fee up to the full cost of the session. Cancellation fees are not submittable to insurance.

Emergencies
Please call 911 or go to the nearest hospital if you have an emergency situation.

Office Hours
Our administrative staff handles phone call Monday - Thursday from 9am to 6pm. Friday's closing is at 5pm. If you call us after hours, please leave a message. We'll respond during the next business day.

Payments
Our therapists appreciate your need for, and will establish with you, a definite understanding regarding financial arrangements. If you are coming to ACP through an Employee Assistance Program (EAP), you may receive some initial sessions at no charge to you. Generally, however, the payment policy is as follows:

- Payments must be made in full at the time of service.
- At your request, we will file an insurance claim for you if you provide all the applicable information requested in the client registration process.

Financial Responsibility
Ultimate financial responsibility for our service rests with you and your family, regardless of insurance coverage. We file insurance claims as a courtesy to you, and do not become involved in disputes between you and your insurance company regarding covered charges, deductibles, etc. We will, of course, provide factual information, as necessary, to assist you.

Receipt of Notice of Privacy Practice & Social Media Policy
You'll find complete information about your protected health information, client rights and responsibilities via the Notice of Privacy Practice. We have copies at the office and on our website. If the Notice is revised, any changes will be posted in our office waiting room and on our website. A new copy of the Notice will be available, if requested.

We want you to know how we conduct ourselves on the Internet and how we will respond to potential online interactions that may occur between our clients and Associated Counseling Professionals. Our Social Media Policy is on our website or available upon request. If you have given your consent on page 3, we will give you a text message reminder of your appointments. Otherwise, please do not email us or contact us on Social Media sites - unless you and your therapist have a written agreement.

__________________________________ ___________________________
Signature of Client or Parent/Guardian Date

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CONSENT FOR TREATMENT

Authorization for Treatment: I, the undersigned, agree and consent to participate in the mental health care offered and provided by ________________________________ [therapist], a mental health professional as defined by Nebraska law. I understand that I am consenting and agreeing only to those mental health services that the above-named professional is qualified to provide within the scope of the professional's license, certifications and training.

Authorized Representative: I hereby authorize Associated Counseling Professionals, its service provider(s) and representatives, to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Associated Counseling Professionals.

The undersigned certifies that he or she has read the foregoing, is the client, client's guardian, power of attorney, or parent, or is duly authorized by or on behalf of the parent to execute the above and accept these terms.

____ _________________________

Signature of Client or Parent/Guardian Date

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By signing this Consent, you are giving us permission to use or disclose your protected health information to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example: quality improvement activities).

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this Consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room and on our website. You may ask for a printed copy of our Notice at any time, or download it from our website.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this Consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the Consent prior to the revocation. This Consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this Consent is not granted, or if the Consent is later revoked.

____ _________________________

Signature of Client or Parent/Guardian Date

____ _________________________

Signature of Witness Date

DISTRESSING EVENT QUESTIONNAIRE
Developed by Leslie K. Pielack, MA

Please answer the questions below as they apply to you. Check all that apply or put a question mark next to an item about which you are uncertain –

Have you experienced any of the following distressing events during any part of your life?

_____ Long separation from one or both parents
_____ Abandonment by caretaker(s) for periods of time
_____ Death of parent(s)
_____ Diagnosis of severe life-threatening illness
_____ Severe/serious injury to self
_____ Severe/serious injury to others
_____ Severe physical discipline or abuse at home
_____ Other violent personal attack (robbery, assault, etc.)
_____ Rape by stranger
_____ Sexual molestation by known person
_____ Witnessed violence toward others
_____ Witnessed physical abuse of others
_____ Witnessed sexual abuse of others
_____ Hostage/kidnapping
_____ Victim of war/military conflict
_____ Military combat/prisoner of war
_____ Political prisoner/torture
_____ Natural or man-made disaster
_____ Unexpectedly witnessing a serious injury, dead body or body parts
_____ Learning of sudden death/serious injury/illness/violent attack of loved one
_____ Experiencing an event which made you feel intensely afraid/helpless/horrified

_____ Other distressing event(s)____

Please indicate which of the following problems you have had:

_____ Recurrent or intrusive recollections/memories of event (images/thoughts/perceptions)
_____ Recurrent distressing dreams of the event or night terrors
_____ Flashbacks: Acting/feeling as if part or all of the event was happening again (reliving the experience illusions, hallucination-type experiences); can occur on awakening or when intoxicated

_____ Intense psychological distress when exposed to internal/external reminders or symbols of the event
_____ Intense physical reaction when exposed to internal/external reminders of the event
_____ Efforts to avoid thoughts, feelings or conversations associated with the event
_____ Efforts to avoid activities, places or people that arouse recollections of the event
_____ Inability to recall an important aspect of the event; blanks in your memory
_____ Loss of interest or participation in significant activities
_____ Feeling numb, having a sense of no feelings or unable to have certain feelings (i.e. loving feelings)
_____ Feeling detachment or estrangement from others
_____ No sense of or hope for future (not expecting to have a career/marriage/children/normal life span)
_____ Reduction in awareness of your surroundings (feeling in a daze)
_____ Feeling like your surroundings are not real or that you are not real or are detached from your body
_____ Difficulty falling or staying asleep
_____ Irritability or outbursts of anger
_____ Difficulty concentrating
_____ Hyper-vigilant (always feeling a sense of alarm, not being able to relax, not feeling safe)
_____ Exaggerated startle response

_____ Other____

Length of time you have been experiencing these problems ______________________________________

Overall, how much have these problems affected your personal/social/occupations well-being? (Circle one)

1. Very Little **2. Somewhat** **3. Significantly** **4. Quite a Lot** **5. Excessively**

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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