Fairbanks Therapy Associates, Inc.
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

Last name		**First name**		**MI**	
DOB			**SS#**		
Address			**City**		
State			**Zip**		
Home phone			**Cell phone**		
Email			**Employer**		
Insurance Co			**Primary insured**		
Insured DOB			**Insured SS#**		
Subscriber ID			**Group #**		
Plan name			**Ins phone**		
Ins address			**Deductible**		

Client Information Date: _____

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

Hello

We are pleased you have chosen to come to Fairbanks Therapy Associates Inc. Our staff looks forward to working with you. We strongly encourage you to take an active role in your counseling experience, and we're pleased to discuss any questions you may have.

Prior to your first appointment, it is important that you discuss our fees with your insurance company and inquire as to whether they accept your counselor's credentials. Ultimately, you are responsible for the fees for services rendered. Thank you.

Our office hours are Tuesday through Friday, 10:00 a.m. to 5:00 p.m. Our office is not open for clients on Monday. In case of an emergency after hours, call 911. After 5 p.m., the agency is officially closed, and clients attending after-hour appointments or groups must be picked up promptly. There is no childcare available at any time.

FTA attempts to assist clients resolve their own problems. We believe that as you and your counselor work together to address your concerns, you will develop a sense of self-awareness that will influence your behavior and feelings. As a therapy client, you may choose to end our professional relationship at any point. We will be supportive of that decision. We also have the option of ending our counseling association if we determine it is necessary. If counseling is successful, you will feel better able to face life's challenges in the future without our support or intervention.

Therapy appointments last fifty (50) minutes (initial____). Everyone at our agency will respect the same level of confidentiality as outlined in our **Notice of Privacy Practices (initial____)**, which is available from our Front Office staff. We will keep confidential anything you say to us, with the following exceptions: (1) you sign a release directing us to tell someone else; (2) we determine you are a danger to yourself or others; (3) suspicion of child abuse or elder abuse; and/or (4) we are ordered by a court to disclose information (initial ___).

FTA assures you that our services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your treatment goals. However, together we will work to achieve the best possible results for you.

By signing this document you are giving your counselor consent to provide mental health services to the identified client. If the client is a minor, your signature confirms your legal authority to sign on behalf of the minor. If you have any questions, feel free to ask. **Please sign and date this form.**

Client Signature _____ Datee _____

Staff Signature _____ Date _____e ____e___

Fairbanks Therapy Associates, Inc.
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

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

Our Pledge Regarding Mental Health Information
The privacy of your mental health information is critically important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and the treatment you receive here. We maintain this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share health information about you. It also
describes your rights and certain duties we have regarding the use and disclosure of protected mental health information.

Our Legal Duty:
Law Requires Us to:
1. Keep your health information privateo
2.dGive you this notice describing our legal duties, privacy practices, and your rights regarding your health information.o
3.dFollow the terms of the notice that is now in effect.o
We Have the Right to:o
1.dChange our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.o
2. Make effective the changes in our privacy practices and new terms of our notice for all health information we keep,o including information previously created or received before the changes.o
Notice of Change to Privacy Practices:o
1. Before we make an important change in our privacy practices, we will change this notice and make the new noticeo available upon request.o

Use and Disclosure of Your Protected Mental Health Information
The following section describes different ways that we use and disclose protected health information. Not every use and disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose health information. ***We will not use or disclose your mental health information for any purpose not listed below without your written authorization. Any specific written authorization you provide may be revoked at any time by submitting a written request to do so.***

- Treatment Purposes: We may use health information about you to provide you with health treatment or services.o We may disclose health information about you to staff who are taking care of you. We may also share informationo about you with other health care providers to assist them in treating you.o
- Payment Purposes: We may use and disclose your health information for payment purposes. We may submito requests for payment to your insurance company. The insurance company maintains the right to request certaino information from us regarding care given. We will provide the required information to them about you and theo care given so that you may access your insurance benefits.o
- Operation Purposes: We may share your health information for our business-related matters, such as audits, billingo services, accounting and legal services. We also may use and disclose your health information for our health careo operations. This may include measuring and improving quality, evaluating the performance of employees,o conducting training programs, and getting the accreditation, certificates, licenses and credentials we need too service you.o

Fairbanks Therapy Associates, Inc.
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

Other Disclosures & Uses Required/Permitted by Law Include:

- Abuse & Neglect: All practitioners of FTA are **mandated** by Alaska State Law to report suspected abuse and neglect of children, elderly, and persons with disabilities.
- Court Proceedings: We may disclose your protected information in the course of any judicial or administrative proceeding as allowed or required by law, with your specific written consent, or as directed by a judge's court order. We do not routinely release protected information in response to an attorney's subpoena.
- Harm to Self or Others: To avert a life-threatening situation, we may disclose your protected information consistent with applicable law to prevent an imminent threat to the health or safety of a person or the public.
- Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of sounds), pursuant to court orders, reporting limited information concerning identification and location at the request of law enforcement officials, reporting death, crimes on our premises, and crimes in emergencies.
- Notification: In the event of an emergency, hospitalization, and with your permission, we may use or disclose your protected information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition. In case of emergency and if you are *not* able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to professional judgment.
- Workers Comp: If you are seeking compensation through Workers Compensation, we may disclose your protected information to the extent necessary to comply with laws relating to Workers Compensation.
- Other Uses: Other uses and disclosures besides those identified in this notice will be made only as authorized by law or with your specific written consent, which you may revoke in writing at any time.

Your Information Rights

The health and billing records we maintain are the physical property of FTA inc. Some of the information in it, however, belongs to you.

You have a right to:

• Request a restriction on certain uses and disclosures of your file by delivering the request in writing to our office. We are not required to grant the request, but we will carefully review any request received.

• Obtain a paper copy of this notice by making a request at our office.

• Request that you be allowed to inspect and/or receive a copy of your file and/or billing record. You may exercise this right by delivering your request in writing to our office. Payment of one dollar per page is due when file copies are picked up.

If you are a parent or legal guardian of a minor, please note that certain portions of the minor's file may not be accessible to you. This determination is made by the minor's therapist if s/he determines that your access to the file would be harmful.

• Request that your file be amended to correct incomplete or incorrect information by delivering a written request to our office. We are not required by law to make such amendments.

• File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your file.

• Obtain an accounting of disclosures of your information as required by law by delivering a written notice to our office. An accounting will not include internal uses for treatment, payment, or disclosures made to you at your request.

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

• Revoke authorizations that you made previously except to the extent information or action has already been taken, by delivering a written revocation to our office.
• Review this notice before signing any consent authorizing use and disclosure of your protected information for treatment, payment, and operation purposes.
If you want to exercise any of the above rights, please contact the Executive Director, L. Hay, (907) 452-2473 by phone or in writing during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibility
FTA inc. is required to:
• Maintain the privacy of your information as required by law;
• Provide you with a notice stating our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this notice;
• Notify you if we cannot accommodate a requested restriction or request; and
• Accommodate your reasonable requests regarding methods to communicate information about you. We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of this notice by calling and requesting a copy or by picking one up at our office.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to file a complaint regarding the handling of your information, you may contact the Executive Director L. Hay at (907) 452-2473 during normal business hours. If you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to L. Hay.

FINANCIAL POLICIES

Thank you for choosing FTA inc. as your behavioral health care provider. We are committed to providing you with the highest quality care available at competitive prices. To continue this service excellence, it is very important that you follow our Financial Policy, which includes prompt payment of your bill. A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with our staff.

PATIENT INTAKE FORM - Please complete the Patient Information Form, which includes demographic, emergency and insurance information. This will ensure correct billing to your insurance carrier. In the event your insurance changes and you do not notify us of the change in time for us to obtain authorizations or file claims within your insurance company's timely filing deadlines, any unpaid fees will become the subscriber's responsibility.

NEW CLIENTS - All new clients are asked to pay the full amount of their first visit at the time of that visit (initial____). Insurance will still be billed, and any overpayment will be applied toward future sessions.

INSURANCE PLANS -We accept most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to determine if your policy covers our providers and services.

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

In many cases, insurance companies request preauthorization prior to seeking treatment. It is your responsibility to obtain this preauthorization.

• Tricare, UHC, Champus or ChampVA – If you are covered by any of these policies, you must check with youro carrier to ensure your therapist is covered under your particular plan. If you are an Active Duty service member,o you must secure an authorization code before your first visit.o

BENEFITS INTERPRETATION -We will do our best to help you understand and interpret your health care benefits. However, it ultimately your responsibility to understand which services are covered and which are not under your plan. If you have any questions, please contact your insurance carrier to help you with this process.

FISCAL YEAR DEDUCTIBLES - It is our policy at the start of each insurance plan's fiscal year to collect the full amount billable for your visit at the time of your visit until your deductible has been met (initial____). Once verification of having met your deductible is made, you will only need to pay your insurance plan's required co-pay or percentage due.

INSURANCE BILLING - Ifdt is determined that your insurance is one that is accepted by FTA inc. we will, as a courtesy, bill your insurance company. If your insurer does not pay for any reason and an appeal is needed, your signature on this *Financial Policy* form serves as a waiver for your insurance company to grant us permission to file one appeal on your behalf (initial____).

MULTIPLE INSURANCE COVERAGE - For those with more than one insurance coverage, we will bill your primary insurance. Please remember that insurance is a contract *between you and your insurer*. We are happy to help as much as we can to ensure payment of your benefits. However, we cannot and will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or what insurance companies refer to as "usual and customary" reductions.

CO-PAYMENT/CO-INSURANCE – After you have met your insurance company's deductible, you must pay all required co-payments or co-insurance payments at the time of your scheduled appointment.

NO-SHOWS AND LATE CANCELLATIONS – FTA inc. is a private non-profit corporation that relies heavily on your prompt payment to keep our services available. In the event you are unable to keep an appointment, you must notify our Front Office at least twenty-four (24) hours in advance. If you do not call to cancel or reschednle your appointment, you will be charged $125.00 for the missed session (initial____). Missed appointment fees are due and payable *before* the next scheduled session. Insurance and/or other third-party coverage *cannot and will not* be billed for no-shows or late cancellations. Because we have a waiting list of clients who need services, if you do not show up for your appointment for two sessions you will be contacted and removed from our schedule until other arrangements are made.

BALANCES OWED AFTER INSURANCE HAS PAID – If there is a balance owed after your insurance(s) has paid, you are responsible for payment of this balance (initial____).

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt and can be made online through our website. FTA inc. reserves the right to discontinue services to you if your account is more than thirty (30) days past due or to refuse services if payments owed at the time of a scheduled service are not paid. Accounts more than ninety (90) days past due or with undeliverable addresses may be forwarded to a collection agency for recovery.

REFUND REQUESTS – Clients who have a credit on their account and would like that amount refunded to them must complete a *Refund Request Form* available from the Front Office staff. Refunds will be made only if the account stands at a zero balance (initial____). If it is determined there are other outstanding balances on your account, the requested refund will be applied to the outstanding balance. You must allow up to thirty (30) days from the time the refund is requested to receive the funds.

ACCOUNT RESPONSIBILITY – It is our policy that we will bill the insurance subscriber for any balances left on accounts. "Accounts" include services rendered to you, a spouse and/or dependents. If any responsible party fails to make timely payments on their portion of the account, we reserve the right to refuse treatment. If you do not have insurance, you are personally responsible for your own debt, and payment is expected at the time of service. In the case of minor patients with no insurance, the adult accompanying the patient is responsible for payments due at the time of service.

By my signature, I confirm that I have read and understood the above financial policies. Any questions I had have been answered.

Name _____ **Signature** _____ **Date** _____

Fairbanks Therapy Associates, Inc.

PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

Billing Information

FTA inc billing rate for an initial intake assessment session is $375.00. Sessions thereafter start at $250.00 per 50 minute session. Our billing rate is based on the reasonable and customary charges billed by other counseling services in the Fairbanks area. Our goals are to (1) assure the highest quality of services and (2) ensure the provision of counseling services to all of those in need. FTA inc. offers a number of options regarding the payment of your bill. Below is a list of third-party billers. If you are in need of special assistance regarding payment of services, please check the appropriate program below.

☐ **Self Pay: I will pay in full at time of service.**

☐ **Insurance: Please bill my insurance company(s). (If my insurance company does not pay for the entire amount of the cost of services, I understand I am responsible for the remainder of the charge.)**

☐ **TriCare client: Dependents do not need pre-authorization; Active Duty Service Members require a referral from their PCM.**

☐ **Chief Andrew Isaac Center Referral: You must have an authorization voucher from TCC. (*If you have insurance, your insurance company must be billed before CAIC is billed.*)**

☐ **Office of Children's Services: A Purchase Authorization must be sent directly to FTA from your case worker. Appointments will be canceled if a proper authorization is not received in time.**

☐ **Division of Vocational Rehabilitation: A Purchase Authorization must be sent directly to FTA from your case worker. Appointments will be canceled if a proper authorization is not received in time.**

☐ **Fairbanks North Star Borough School District: A Purchase Authorization must be sent directly to FTA from your case worker. Appointments will be canceled if a proper authorization is not received in time.**

☐ **Credit Card Payment: Please charge my credit card at the time of service.**

☐ **VISA** ☐ **MasterCard**

Acct.#_____ Exp. Date: _____ 3 Digit Code: _____

I authorize the release of relevant information to my insurance carrier or other provider as required to establish benefits, and I agree to assign those benefits to FTA inc. This authorization is valid unless I revoke it in writing. It may be revoked or renewed as desired by both parties.

Printed Name _____ Signature _____ Date _____

Fairbanks Therapy Associates, Inc.
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

This Notice Describes How Treatment Information About You May Be Used and Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

When you receive treatment from the FTA inc. we will obtain and/or create health information about you. Health information includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) the health care provided to you; and (3) the past, present, or future payment for your health care.

The following notice tells you about our duty to protect your health information, your privacy rights, and how we may use or disclose your health information.

FTA's Duties:
The law requires us to protect the privacy of your health information. This means that we will not use or let other people see your health information without your permission except in the ways we tell you in this notice. We will safeguard your health information and keep it private. This protection applies to all health information we have about you, no matter when or where you received or sought services. We will not allow any unauthorized person to interview, photograph, film, or record you without your written permission. We will not tell anyone if you sought, are receiving, or have ever received services from FTA, unless the law allows us to disclose that information.

We will ask you for your written permission (authorization or consent) to use or disclose your health information. There are times when we are allowed to use or disclose your health information without your permission, as explained in this notice. If you give us your permission to use or disclose your health information, you may take it back (revoke it) at any time. If you revoke your permission, we will not be liable for using or disclosing your health information before we knew you revoked your permission. To revoke your permission, send a written statement, signed by you, to FTA, providing the date and purpose of the permission and saying that you want to revoke it.

We are required to give you this notice of our legal duties and privacy practices, and we must do what this notice says. We can change the contents of this notice and, if we do, we will give you an updated copy. The new notice will apply to all health information we have, no matter when we got or created the information.

Our employees must protect the privacy of your health information as part of their jobs. We do not let our employees see your health information unless they need it as part of their jobs. We will discipline employees who do not protect the privacy of your health information. If you are also being treated for alcohol or drug abuse, your records are protected by federal law and regulations found in the Code of Federal Regulations at Title 42, Part 2. Violation of these laws that protect alcohol or drug abuse treatment records is a crime, and suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law will not protect any information about a crime committed by you either at FTA or against any person who works for FTA or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Your Privacy Rights at FTA
If you make a request in advance, you can obtain a copy of you the health information that we have about you. There are some reasons why we will not let you see or get a copy of your health information, and if we deny your request we will tell you why. You can appeal our decision in some situations. You can choose to get a summary of your health information

instead of a copy. If you want a summary or a copy of your health information, you may have to pay a reasonable fee for it.

You can ask us to correct information in your records if you think the information is wrong. We will not destroy or change our records, but we will add the correct information to your records and make a note in your records that you have provided the information.

You can get a list of the disclosures of your health information that we made to other people. The list will not include disclosures for treatment, payment, health care operations, national security, law enforcement, or disclosures where you gave your permission. The list will not include disclosures made before April 14, 2003.

There will be no charge for one list per year. You can ask us to limit some of the ways we use or share your health information. We will consider your request, but the law does not require us to agree to it. If we do agree, we will put the agreement in writing and follow it, except in case of emergency. We cannot agree to limit the uses or sharing of information that are required by law. You can ask us to contact you at a different place or in some other way. We will agree to your request as long as it is reasonable. You can get a copy of this notice any time you ask for it.

Treatment, Payment, and Health Care Operations
We may use or disclose your health information to provide care to you, to obtain payment for that care, or for our own health care operations. We can use or disclose your health information to provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider. Unless you ask us not to, we may also contact you to remind you of an appointment or to offer treatment alternatives or other health-related information that may interest you.

Payment: We can use or disclose your health information to obtain payment for providing health care to you or to provide benefits to you under a health plan. For example, we can use your health information to bill your insurance company for health care provided to you.

Health Care Operations: We can also use your health information for health care operations:
activities to improve health care, evaluating programs, and developing procedures; case management and care coordination; reviewing the competence, qualifications, performance of health care professionals and others; conducting training programs and resolving internal grievances; conducting accreditation, certification, licensing, or credentialing activities; providing medical review, legal services, or auditing functions; and engaging in business planning and management or general administration. For example, we can use your health information to develop procedures for providing care to people at our agency.

Fairbanks Therapy Associates, Inc.
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FairbanksTherapyAssociates.com

FTA may only disclose information about your treatment for alcohol or drug abuse without your permission in the following circumstances:

Pursuant to a special court order that complies with 42 Code of Federal Regulations Part 2 Subpart E;

- To medical personnel in a medical emergency;
- To qualified personnel for research, audit, or program evaluation;
- To report suspected child abuse or neglect;
- Federal and State laws prohibit re-disclosure of information about alcohol or drug abuseo
- treatment without your permission.
- Federal rules restrict any use of information about alcohol or drug abuse treatment to criminally investigate oro prosecute any alcohol or drug abuse patient.

I hereby acknowledge that I have received and have read a copy of FTA inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact FTA at 452-2473.

Signature of Client _____ Date: _____

Witness _____ Date: _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for payment, or clinical operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for payment, and clinical operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. LEAP inc. provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The client understands that:

- Protected health information may be disclosed or used for payment, or clinical operations.
- LEAP inc. has a Notice of Privacy Practices and that the client has the opportunity to review this notice.
- LEAP inc. reserves the right to change the Notice of Privacy Practices.
- The client has the right to restrict the uses of their information but LEAP inc. does not have to agree to those restrictions.
- The client may revoke the Consent in writing at any time and all future disclosures will then cease.
- As a client, you have the right to see your file, unless it would endanger your health or another person's health or safety. Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.

Use or disclosure of the following protected health information does not require your consent of authorization:

- Uses and disclosures required by law-like files court-ordered by a Judge
- Uses and disclosures about victims of abuse, neglect, or domestic violence-like the duties to warn explained in the Disclosure Statement
- Uses and disclosures for health and oversight activities-like correcting records or correcting records already disclosed
- Uses and disclosures for judicial and administrative proceedings-like a case where you are claiming malpractice or breech of ethics
- Uses and disclosures of law enforcement purposes-like if you intend to harm someone else
- Uses and disclosures to avert a serious threat to health or safety-like calling Probate Court for a commitment hearing
- When billing health insurance
- In the matter of a grievance report

Client Printed Name	Client Signature	Date

PO Box 82842
Fairbanks, AK 99708
p. 907.452.2473
f. 907.452.6903
www.LEAPFbks.com

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FTALEAPFbks.com

Consent Release & Exchange of Confidential Information

I, _____DOB: _____give authorize Fairbanks Therapy Associates (FTA) to release and receive confidential information to/from the following agency(ies):

(please initial)

Adult Probation (DOC)
Alaska Court System
Alaska State Troopers (AST)

Child Custody Investigator:
_____
Child Support Enforcement (CSED)
Council on Domestic Violence and Sexual Assault (CDVSA)
District Attorney (DA)

Fairbanks Police Department (FPD)
Guardian ad litem (GAL)
Interior Alaska Center for Non-Violent Living (IAC)
Office of Children's Services (OCS)

Office of Public Advocacy (OPA)
Public Defender (PD)

Other: _____

I authorize confidential information to be released from:

_____

to Fairbanks Therapy Associates Inc. (FTA) home of the LEAP program at PO Box 82842 Fairbanks, AK 99708 907-452-2473 fax: 452-6903. Encrypted email: secure@LEAPFbks.hushmail.com

The PURPOSE of this consent is to improve assessment and treatment planning, share information, share information relevant to treatment and, when appropriate, coordinate treatment services. I understand that the Provider cannot guarantee that the Recipient will not re-disclose my confidential information to a third party. I understand that I have a right to revoke this consent, in writing, at any time by sending written notification to the receptionist at FTA. I further understand that a revocation of the consent is not effective to the extent that action has been taken in reliance on the consent. I further understand that FTA will not condition my treatment on whether I give consent for the requested disclosure. Unless you have specifically requested in writing that this disclosure be made in a certain format, we reserve the right to disclose information as permitted by this consent in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format or electronically. I will be provided a copy of this consent at my request. This consent for the release of information shall begin on the date of my signature and shall remain in effect for the next twelve months or until I have notified FTA Inc., in writing, of otherwise.

Client Signature: _____ Date: test

Witness: _____

RECIPIENT INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any other disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal roles restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Fairbanks Therapy Associates, Inc.
home of the LEAP program
PO Box 82842 Fairbanks, AK 99708 p: 907-452-2473 f: 452-6903
LEAP@LEAPFbks.com www.FTALEAPFbks.com

CREDIT CARD ON FILE POLICY

At FTALEAP Inc. we require keeping your credit or debit card in file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable and/or for any balance that is over sixty (60) days aged. Without this authorization, all initial services must be paid at the time of service. Your credit card information will be kept confidential and secure in a locked filing cabinet within your personal file. We will make you aware of charges before running your card at any time.

I authorize FTA/LEAP, Inc. to charge the portion of my bill that is my financial responsibility over sixty (60) days aged to the following credit or debit card:

○ Amex ○ Visa ◉ Mastercard ○ Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder Name: _____

Billing Zip Code: _____

Client allowed Credit Card on file: _____

Date: _____

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL# _____

Client intake form

☐ ☐
Yes No Initial:

Today's Date: _____ Text Reminders?

CLIENT INFORMATION

Name: _____ Age: _____ Date of Birth _____

Physical Address: _____
Street address City State Zip Code

Mailing Address: _____
Mailing address City State Zip Code

Email:

Home Phone: _____ Work Phone: _____

Social Security Number: _____

Ethnic Group: ☐ Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Filipino ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Other: _____

Education: (Circle highest grade completed)

6 7 8 9 10 11 12 ☐ GED College: 1 2 3 4 5+

Place of birth? _____ Raised? _____

Occupation: _____ Yearly Income: _____

Employer: _____ How long? _____

Employer's Address: _____
Street address City State Zip Code

Do you have Health Insurance? ☐ Yes ☐ No Name of Company _____

Military Experience: From: _____ To: _____ Branch: _____

Type of Discharge: _____ Combat experience? _____

REFERRAL INFORMATION

How did you learn about LEAP? _____

Have you been to LEAP before? Yes No When? _____

Are you Court Ordered to LEAP? Yes No Case #? _____

Do you have a court case pending? Yes No Hearing Date? _____

Do you or your partner currently have any involvement with OCS (DFYS)? YES☐ NO☐

Have you or your partner (or any children who live with you) had any past involvement with OCS? ☐ ☐

If you answered "yes" to either of the last two questions concerning OCS, please explain: _____

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

VICTIM AND PARTNER INFORMATION
(for victim and current or most recent partner)

Partner Name: _____ Age: _____ Date of Birth: __/__/____

Physical Address: _____
Street address City State Zip Code

Mailing Address: _____
Mailing address City State Zip Code

Home Phone: _____ Work Phone: _____

Ethnic Group: Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Filipino ☐ Hispanic ☐ Native America ☐ Pacific Islander ☐ Other: _____ ☐

Are you and your partner currently living together? Yes No

Current Status: Married Living together Separated Divorced Other _____

Length of time in current relationship? _____

When did relationship begin? _____ When did you first start living together? _____

Date of marriage? _____ Separation? _____ Divorce? _____

How would you describe your relationship? _____

_____

Is it your goal to remain in the relationship? Yes ☐ No ☐ Not su ☐

Has your partner ever stayed at the Women's shelter? Yes ☐ No ☐ Not Sure ☐

Has your partner ever received counseling from IAC? Yes ☐ No ☐ Not Sure ☐

Victim Name: _____ Age: _____ Date of Birth: __/__/____

Physical Address: _____
Street address City State Zip Code

Mailing Address: _____
Mailing address City State Zip Code

Home Phone: _____ Work Phone: _____

_____ _____

Ethnic Group: Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Filipino ☐ Hispanic ☐ Native America n ☐ Pacific Islander ☐ Other: _____ ☐

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL# _____

Your Children

Name	Sex	dob		Other parents name		

Do you think the children have been affected by the conflict at home?

No Slightly Moderately Greatly N/A

Have the children witnessed any violence or arguments? Yes ☐ No ☐

PREVIOUS RELATIONSHIP HISTORY

Dates of relationship	Length of relationship	Present ages of children from this relationship	With whom do these children live now?

Was there any violence in any of these relationships? Please describe.

HISTORY OF ABUSE

Give a summary of the incident that got you involved with LEAP.

Date of incident: _____ What happened? _____

_____

_____

_____

Had you been drinking or using drugs at the time of your violence? Yes ☐ No ☐

What types of injuries resulted from this Incident?

None ☐ Bruises ☐ Broken bones ☐ Internal injuries ☐

Wounds (punctures) ☐ Chronically Disabling ☐ Treatment Needed ☐

When did you first use violence in this relationship? (Circle your answer below)

Before living together After living together During partner's pregnancy Date started _____

Describe the most violent incident you have committed: _____

LEAP inc.

Referral: _____ Intake clinician: _____ APSIN/DL#_____

☐ Before living together ☐ After living together ☐ During partner's pregnancy Date started _____

Describe the most violent incident you have committed: _____

_____

Have you ever done any emotional, physical, or sexual abuse in a previous relationship? Yes☐ No☐

CHILDHOOD/FAMILY HISTORY

Were you raised by? Bio. Parents☐ Step-parents☐ Other Adult☐

How would you describe your father (or the man who primarily raised you)? _____

_____

_____

How would you describe your mother (or the woman who primarily raised you)? _____

_____

_____

Did your mother drink during her pregnancy? _____

Who was primarily responsible for discipline? _____

How were you typically disciplined or punished? _____

What was the most severe punishment you received? _____

Do you have any siblings? How many? _____

Looking back, do you consider yourself to have been:

Punished severely?	Yes ☐	No ☐	Maybe ☐
Punished unfairly?	Yes ☐	No ☐	Maybe ☐
Physically or	Yes ☐	No ☐	Maybe ☐
Emotionally abused?	Yes ☐	No ☐	Maybe ☐

Please explain: _____

_____

_____

Were you ever sexually abused during your childhood? Yes☐ No☐

If yes, how old were you and who committed the abuse? _____

Did you ever see the persons who raised you fight or argue? (Circle your answer)

Never	Rarely	Sometimes	Often	Very Often
☐	☐	☐	☐	☐

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

Never Rarely Sometimes Often Very Often

Did you ever see or hear your mother (or adult female) push, slap, or hit your father?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often

Did you ever witness any other violence in the family or place you grew up? Yes ☐ No ☐

Please explain: _____

_____

LEGAL HISTORY

Have you ever been arrested? Yes ☐ No ☐ If yes, please indicate history of arrests below beginning with most recent arrest.

DATE OF ARREST	CHARGE	LENGTH OF JAIL TIME

Any other domestic violence related arrests? Yes ☐ No ☐ If yes, what were the charges and When did they occur? _____

_____

Any other assault charges? _____

_____

How many times have the police been called to your house because of family disputes? _____

Are you currently on probation? Yes ☐ No ☐ For what charge? _____

Name of probation officer: _____

Is there currently a TRO (Temporary Restraining Order) in effect? Yes ☐ No ☐

Have you had previous restraining orders with your current partner? Yes ☐ No ☐

If yes, how many? _____

Have you had any restraining orders with past partners? Yes ☐ No ☐

If yes, how many? _____

Do you own any weapons? Yes ☐ No ☐ What kind? _____

Who currently has access to them? _____

Have you ever used weapons (or an object as a weapon) against your partner? Yes ☐ No ☐

If yes, please describe: _____

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL# _____

DRUG/ALCOHOL USE

How often do you drink?

☐ Never ☐ Less than once/month ☐ Several times/month ☐ 1-2 times/week ☐ 3-5 times/week ☐ Daily

How many drinks do you typically have per time? _____

When did you last drink? _____ Last time intoxicated? _____

How many drinks does it take to become intoxicated? _____

Does it take ***More, Less,*** or the ***Same*** amount to get drunk as it did several years ago? _____

Have you ever forgotten what happened during a period of time while you had been drinking?

(i.e. blackouts)? Yes☐ No☐ How many times has this happened? _____

Have you ever been arrested for a DWI? Yes ☐ No☐ How many times _____

Any other alcohol related arrests? Yes ☐ No ☐ For what? _____

Has drug or alcohol use affected your job performance? Yes☐ No☐

Have you ever been fired from a job because of alcohol or drug use? Yes☐ No☐

Age of first drink? _____ Age of first regular use of alcohol? _____

Is there any history of alcoholism in your family? Yes ☐ No ☐

If so, who: _____

Do you use any other drugs? Yes☐ No ☐ What kind? _____

How frequently? _____ How much per time? _____

Have you ever been arrested for a drug-related offense? Yes☐ No☐

When? _____ What was the offense? _____

Have you ever received treatment for drug/alcohol abuse? Yes☐ No☐

Where?	When?

Do you get emotionally, physically or sexually abusive when you drink or use drugs? Yes☐ No☐

If yes, in what way? _____

LEAP inc.

Referral: Intake clinician: ASPIN/DL#

Do you think your alcohol/drug use affects your relationship with your partner or family? Yes☐ No☐

If so, how? _____

_____

Do you have any allergies or health issues? If so what?

_____

Are you currently taking any prescription medications? Yes☐ No☐ If yes, please specify:

_____

Are you currently involved in any other type of counseling? Yes☐ No☐

If so, who are you seeing? _____

Have you been diagnosed with a mental illness? Yes☐ No☐ Specify: _____

Have you recently thought of hurting yourself? Yes☐ No☐ When? _____

What did you consider doing? _____

_____

What stopped you? _____

Have you ever attempted suicide in the past? Yes☐ No☐ If yes, explain: _____

Any current homicidal or suicidal ideations? _____

Any current feelings of depression or anxiety?

_____

_____

May we send you text reminders? _____

Client signature for text reminders: _____

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

Client Treatment Agreement

Please ***initial*** after each line in space provided

I,_____ voluntarily enter into this agreement with LEAP Inc. for all staff to provide me with treatment services. (Throughout this document " I, my, and me" will refer to the client.) I understand and agree to the following:

1.e My violence/abusive behavior/beliefs are assessed as a problem. I agree that in order to participate ine the treatment programs it is necessary for me to talk openly about my violence/abuse/beliefs.e

_____

2.e I will use no violence/abuse while I am in program. This includes emotional, psychological, spiritual,e physical and sexual violence while in the program. _____e

3.e I will not be violent or abusive in my treatment group or individual treatment sessions. I will treate staff and other group members respectfully or I will be told to leave the premises, and I will comply.e

_____

4.e When I come to LEAP I will be clean and sober. I will not be under the influence of anything thate negatively effects my ability to participate in group. _____e

5.e While at LEAP, I will secure by lock or relocation any firearms or weapons I may own or possess. Ie will not attend a LEAP session in possession of any weapon, including knives. If I do this may resulte in being discharged from program. _____e

6.e IAC will make Safety Checks; contacting my present and past partners, spouses and dependents.e These will occur throughout the treatment program, and may continue for 1 year after completinge treatment. I will not interfere with this process. _____e

7.e I will keep confidential any names or information about other persons attending LEAP program othere than myself to any other persons or agencies other than LEAP. I will maintain confidentiality. _____e

8.e I will pay for all scheduled services via whatever payment arrangement has been made with LEAP. Ie will not carry an outstanding balance. _____e

9.e I will not miss more than 3 scheduled sessions, classes, groups, etc. in a 9 month period of time. I cane negotiate a Leave of Absence with LEAP staff. (A scheduled Leave of Absence is not considered toe be a missed session.) _____

10.eIf I miss more than 3 sessions I will be required to complete a make up session within 2 weeks.e

_____

11.eI will not participate in couples or relationship counseling until I have been free of violence ande coercive behavior for a minimum of six months. _____e

12.eI will work hard to make continual treatment progress, as measured by staff/professional opinion.e

_____

13. I will attend the group reasonably groomed and dressed.e_____

14.eThroughout the duration of this program I will disclose to LEAP any violations of this contract.e

_____

15.eFailure to comply with any of the above points may lead to my termination from group. A notice ofe termination will be forwarded to victim/current partner and the following agencies (Adulte Parole/Probation; State, Federal, Local Court; OCS, etc.) _____e

16.eSessions may be observed by other LEAP staff or persons who have a legitimate interest in observinge treatment meetings for training purposes. No session will be observed without prior notice to you.e Any observer will sign consent to confidentiality._____e

17.eAs outlined by the Department of Health and Human Services regulations (42 CRF Part 2) noe disclosure of a client's/patient's record can be compelled unless permitted by the regulations, or aftere

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

obtaining written consent. (This does not apply in a case where physical or sexual abuse or neglect of a child or vulnerable adult has been disclosed, or where intent to harm self or others has been disclosed). _____

18. LEAP is required by the state to immediately disclose the following information to the program participant's victim, current partner, sentencing court, probation/parole and law enforcement, and if appropriate local victim agency): threats or actual destruction of property; threats to violate, attempts to violate, or violations of child custody or child visitation orders; and threats of physical harm or actual physical harm or any person or pet. _____
19. I understand that in order to have been considered to have successfully completed LEAP I will have to attend and participate in all 36 program classes, complete all homework, pay all fees, be able to demonstrate during groups – an increase in insight, knowledge and development of new skills. I will also be required to complete and pass a post test with a score of 90% or higher. _____
20. If I do not pass the post test I will be extended six classes and be given another chance to take the post test in hopes of passing. _____
21. LEAP reserves the right to deny treatment or cease the treatment relationship if seen as necessary. _____
22. I will comply with all the conditions of my Treatment Agreement and follow any recommendations made by the program if additional services are deemed necessary. _____

_____ _____

Client Signature Date

_____ _____

Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

VICTIM

Client Consent for the Release of Confidential Information

I, _____ authorize LEAP, Inc.

to exchange with _____
victim and/or current partner

the following information: my attendance, participation and any issues of lethality that may arise.

Purpose: to provide for the safety of victim and/or current partner.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e.: probation, parole, ect) and that in any event this consent expires automatically twelve months after termination from the program.

_____ _____
Client Signature Date

_____ _____
Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

Client Treatment Plan

I _____ acknowledge that in order to successfully complete the LEAP Alternatives to Violence Program, I must first accomplish the following goals and meet the related objectives by:

1. Committing no acts of physical or sexual violence for the duration of the program.

2. Attending, participating in, and completing homework for a minimum of 36 group sessions.

3. Demonstrating satisfactory progress while in program.

4. Passing a comprehensive Post Test.

I understand and agree that if I meet these requirements I will complete the ATV program in not less than 36 weeks. I also understand that if I become non-compliant with the program an affidavit of non-compliance will be filed with the courts, I will lose credit for any classes I have completed to that point, and I will start the program over.

_____ _____

Client Date

_____ _____

Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

Client Payment Agreement

1. I am responsible for making payments for all billable services I receive. This includes intake and individual sessions, groups, classes and make up classes. No more than a total of five make up sessions can be done unless you have prior approval by the Executive Director. The group/class fee is $50.00. Individual sessions are $180.00 per hour. As a courtesy, we will bill your insurance for you. However, you are responsible for any unpaid insurance claims after 60 days.

2. I will pay for services at the time I receive them.

3. Advance payments for the program are welcome. A discount will be given on payment in advance. Speak with the Program Director concerning this policy.

4. In order to complete the program, my balance must be zero. If there are unpaid insurance claims still pending, the client is responsible for that cost. If insurance ultimately comes through and pays the claim, you will be reimbursed.

5. LEAP does not accept personal checks. We do accept cash, credit or debit card.

_____ _____

Client Date

_____ _____

Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

Absence Policy

The LEAP program allows three absences without penalty during the thirty-six weeks of class. The fourth absence will result in being filed non-compliant. This will result in a letter of non-compliance being sent to the court, the prosecutor's office, other relevant agencies, and to your partner and/or victim. A client can become compliant again by doing a make-up session to cover that absence. That make-up class must be done within two weeks of the missed class. Make-up classes are available at the cost of: $180.00 for an individual, $90.00 if there are two attendees. $75 if more than 3 attendees

Leave of Absence

If you are to be away from the Fairbanks area for an extended period of time you may request a leave of absence. Any leave of absence will require you to know the materials covered during your period of absence. The cost of a Leave of Absence is $50.00

Attendance

Nothing in the discussion above, in any way, excuses you from participating in the full thirty-six weeks of sessions.

I have read and understand LEAP's Absence Policy.

_____ _____

Client Signature Date

_____ _____

Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

North Slope/Rural Policy

If your job takes you up North (or somewhere else), or you live out of town, then when you are in Fairbanks you will be required to attend one group a week, and do one make-up group a week. The cost of a make-up group is $180.00. If you are able to arrange to do a make-up class with another client who needs one, the cost of that make-up goes down to $90.00. During the time you are away from program you will be required to make contact (telephone, electronic) with LEAP weekly and complete assigned homework.

I have read and understand LEAP's North Slope/Rural attendance Policy.

_____ _____

Client Signature Date

_____ _____

Witness Date

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL# _____

CLIENT RIGHTS

LEAP assures you have the following privileges and rights in your treatment with LEAP.

A. You have the right to be treated with respect and dignity.

B. You have the right to be assured of privacy and confidentiality regarding your treatment, in keeping with State laws.

C. You have the right to have an individual service treatment to participate in the development of the plan, and to be involved in deciding any changes in the plan.

D. You have the right to be fully informed about fees you will be charged and how the fees can be paid. You may also ask for a review of a set fee at any time.

C. You have the right to ask the LEAP Executive Director to review your treatment program if you are not satisfied.

D. You have the right to be provided services which are consistent with normal standards of treatment for the goals of your program.

E. You also have the right to be told about LEAP policies/procedures which affect you, and which also have to do with canceling or changing appointment times.

F. You have the right to review your treatment records and reports generated by Life Education Action Program with your therapist.

G. You have the right to receive treatment which is non-discriminating and sensitive to differences in race, culture, language, sex, origin, disability, creed, socioeconomic status and sexual orientation.

H. You have the right to be free from being sexually harassed or sexually abused.

I. You have the right to enter a complaint to the Executive Director of LEAP if you feel your rights have not been upheld.

J. You have the right to be informed that LEAP abides by a duty to warn policy that is in agreement with AS 25.35.100 and AS 23.35.110 including, but not limited to, notifying potential victims of threats made by the client.

LEAP inc.

Referral: _____ Intake clinician: _____ ASPIN/DL#_____

ABSTINENCE CONTRACT

I,_____, in order to insure the safety of victims and the community agree to abstain from alcohol and all mood altering substances while attending treatment at LEAP. If I am unable to do so I will discuss this with my counselor. This may result in referral to a treatment program for substance abuse.

_____ _____

Client's signature Date

_____ _____

Witness Date

LEAP - Behavior Inventory

Please indicate how frequently you have directed the following behaviors towards your current partner, and other adults.

A=1-5 times B= 6-10 times C=11-15 times D=16+

partner	other	
☐	☐	raise hand
☐	☐	unwanted touching
☐	☐	restrain
☐	☐	pull hair
☐	☐	scratch
☐	☐	shake
☐	☐	pinch
☐	☐	push/shove
☐	☐	bruise
☐	☐	slap
☐	☐	throw objects
☐	☐	kick
☐	☐	bite
☐	☐	break bones
☐	☐	burn
☐	☐	scald
☐	☐	punch
☐	☐	damage face
☐	☐	choke
☐	☐	blind/deafen
☐	☐	threaten w/weapon
☐	☐	cut
☐	☐	stab
☐	☐	shoot
☐	☐	disable
☐	☐	beat w/ weapon
☐	☐	fatally injure
☐	☐	attempt to kill
☐	☐	kill

partner	other	
☐	☐	hurtful jokes
☐	☐	insult/put down
☐	☐	denial of $ or emotional support
☐	☐	break objects
☐	☐	label/name calling
☐	☐	discredit beliefs, choices
☐	☐	shout/yell
☐	☐	ignore
☐	☐	blame
☐	☐	embarrass
☐	☐	double standards
☐	☐	guilt trips
☐	☐	threaten to take kids
☐	☐	use children
☐	☐	intimidate
☐	☐	disable phone
☐	☐	isolate
☐	☐	jealousy
☐	☐	threats
☐	☐	abandonment
☐	☐	interrupt sleep or eating
☐	☐	change reality
☐	☐	drive recklessly
☐	☐	chase w/ vehicle
☐	☐	threaten to injure children
☐	☐	stalk
☐	☐	injure/kill pet
☐	☐	refuse medical treatment
☐	☐	threaten to kill

partner	other	
☐	☐	compare to others sexually
☐	☐	humiliate
☐	☐	accuse of being unfaithful
☐	☐	degrade sexually
☐	☐	unwanted fondling
☐	☐	insult: slut, whore
☐	☐	children witness/watch
☐	☐	strip clothes
☐	☐	transmit an STD
☐	☐	dominate sexually
☐	☐	use object(s) during sex
☐	☐	sex when she's sleeping
☐	☐	use pornography
☐	☐	injure breasts/genitals
☐	☐	guilt trips re: sex/sexual acts
☐	☐	demand sex
☐	☐	objectify
☐	☐	sex after violence
☐	☐	swap/swing
☐	☐	s&m
☐	☐	prostitute
☐	☐	use weapons during sex
☐	☐	sex through force or threat
☐	☐	rape
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

LEAP - Behavior Inventory

Please indicate how frequently you have <u>experienced</u> the following behaviors from your current partner, family, and other adults.

A=1-5 times B= 6-10 times C=11-15 times D=16+

partner	family	other	
☐	☐	☐	raise hand
☐	☐	☐	unwanted touching
☐	☐	☐	restrain
☐	☐	☐	pull hair
☐	☐	☐	scratch
☐	☐	☐	shake
☐	☐	☐	pinch
☐	☐	☐	push/shove
☐	☐	☐	bruise
☐	☐	☐	slap
☐	☐	☐	throw objects
☐	☐	☐	kick
☐	☐	☐	bite
☐	☐	☐	break bones
☐	☐	☐	burn
☐	☐	☐	scald
☐	☐	☐	punch
☐	☐	☐	damage face
☐	☐	☐	choke
☐	☐	☐	blind/deafen
☐	☐	☐	threaten w/weapon
☐	☐	☐	cut
☐	☐	☐	stab
☐	☐	☐	shoot
☐	☐	☐	disable
☐	☐	☐	beat w/ weapon
☐	☐	☐	fatally injure
☐	☐	☐	attempt to kill
☐	☐	☐	kill

partner	family	other	
☐	☐	☐	hurtful jokes
☐	☐	☐	insult/put down
☐	☐	☐	denial of $ or emotional support
☐	☐	☐	break objects
☐	☐	☐	label/name calling
☐	☐	☐	discredit beliefs, choices
☐	☐	☐	shout/yell
☐	☐	☐	ignore
☐	☐	☐	blame
☐	☐	☐	embarrass
☐	☐	☐	double standards
☐	☐	☐	guilt trips
☐	☐	☐	threaten to take kids
☐	☐	☐	use children
☐	☐	☐	intimidate
☐	☐	☐	disable phone
☐	☐	☐	isolate
☐	☐	☐	jealousy
☐	☐	☐	threats
☐	☐	☐	abandonment
☐	☐	☐	interrupt sleep or eating
☐	☐	☐	change reality
☐	☐	☐	drive recklessly
☐	☐	☐	chase w/ vehicle
☐	☐	☐	threaten to injure children
☐	☐	☐	stalk
☐	☐	☐	injure/kill pet
☐	☐	☐	refuse medical treatment
☐	☐	☐	threaten to kill

partner	family	other	
☐	☐	☐	compare to others sexually
☐	☐	☐	humiliate
☐	☐	☐	accuse of being unfaithful
☐	☐	☐	degrade sexually
☐	☐	☐	unwanted fondling
☐	☐	☐	insult: slut, whore
☐	☐	☐	children witness/watch
☐	☐	☐	strip clothes
☐	☐	☐	transmit an STD
☐	☐	☐	dominate sexually
☐	☐	☐	use object(s) during sex
☐	☐	☐	sex when she's sleeping
☐	☐	☐	use pornography
☐	☐	☐	injure breasts/genitals
☐	☐	☐	guilt trips re: sex/sexual acts
☐	☐	☐	demand sex
☐	☐	☐	objectify
☐	☐	☐	sex after violence
☐	☐	☐	swap/swing
☐	☐	☐	s&m
☐	☐	☐	prostitute
☐	☐	☐	use weapons during sex
☐	☐	☐	sex through force or threat
☐	☐	☐	rape
☐	☐	☐	
☐	☐	☐	
☐	☐	☐	
☐	☐	☐	
☐	☐	☐	

v

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks**
(enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
c. Did you receive treatment for anything that changed?..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage?..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step?..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much? ..... ☐ Yes ☐ No
37. Do you think you might have a problem with alcohol, drug or inhalant use?..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you often feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score