Fairbanks Therapy Associates Inc.

helping navigate life's journey

Welcome to Fairbanks Therapy Associates Inc. (FTA)

Home of the LEAP program

Please have your insurance card, photo ID and credit card ready when you check in. Due to the recent chances with insurance company policies and due to their inconsistencies with payment, at this time, Fairbanks Therapy Associates (FTA) and LEAP requests your credit card information (this may be a health spending account card, or a credit/debit card) and authorization to be placed on file for all visits.

- This preauthorization will allow FTA to collect balance due after your insurance has processed visit charges (if applicable).
- No charges will be applied to your credit card unless your insurance plan indicates that you are responsible for charges under the guidelines of your coverage. You would also receive an EOB (explanation of benefits) in the mail stating this.
- FTA secures credit card data and protects it within FTA's network. FTA meets payment card industry standards.
- After your insurance provider processes your claim for visits and notifies FTA of your responsibility, we will apply the charges to your card up to the amount you authorize.
- You will receive an acknowledgement receipt of your credit card authorization confirming the final amount charged.

If you are not comfortable with this process – you can pay for your appointment in full and we can give you an itemized statement that you can use to submit to your insurance company for reimbursement.

Fairbanks Therapy Associates Inc.
PO Box 82842, Fairbanks, AK 99708
907-452-2473 f: 452-6903
www.FairbanksTherapyAssociates.com
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Client Information **Date:** _____

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**		
Copay					

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Hello

We are pleased you have chosen to come to FTA 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 fee 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 clinicians work to assist clients in resolving the challenges in their lives. 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 _____ Date _____

Staff Signature _____ Date _____

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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 private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your health information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make effective the changes in our privacy practices and new terms of our notice for all health information we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

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 protected 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. We may disclose health information about you to staff who are taking care of you. We may also share information about you with other health care providers to assist them in treating you.
- Payment Purposes: We may use and disclose your health information for payment purposes. We may submit requests for payment to your insurance company. The insurance company maintains the right to request certain information from us regarding care given. We will provide the required information to them about you and the care given so that you may access your insurance benefits.

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- Operation Purposes: We may share your health information for our business-related matters, such as audits, billing services, accounting and legal services. We also may use and disclose your health information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to service you.

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.

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• 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.
• 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.

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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. In many cases, insurance companies request preauthorization prior to seeking treatment. It is your responsibility to obtain this preauthorization. Additionally, insurance companies often change the provider payment rate, and co-insurance amounts without notification. **Clients are responsible for keeping up with this information and for paying the balance that is not covered by their insurance.**

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

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 - If it is determined that your insurance is one that is accepted by FTA Inc. we will, as a courtesy will bill your insurance. 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____)**.

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MULTIPLE INSURANCE COVERAGE - For those with more than one insurance coverage, we will bill your primary insurance first. Once payment is received from that primary insurance company, we then will bill your secondary insurance company one time. 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 reschedule your appointment, you will be charged $175.00 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____)**. 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. 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 will be forwarded to a collections 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 –"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 _____

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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 with our senior clinician or $180 for 50 minute session with a junior clinician. 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 with the appropriate program listed below directly.**

☐ 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 _____

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 and/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.

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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.

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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.

Unless you are receiving treatment for alcohol or drug abuse, FTA is permitted to use or disclose your health information without your permission for the following purposes.
When required by law. We may use or disclose your health information as required by state or federal law.

- **To report suspected child abuse or neglect.** We may disclose your health information to a government authority if necessary to report abuse or neglect of a child.

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- **To address a serious threat to health or safety.** We may use or disclose your health information to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.
- **For research.** We may use or disclose your health information if a research board says it can be used for a research project, or if information identifying you is removed from the health information. Information that identifies you will be kept confidential.
- **To a government authority if it is reported that you are a victim of abuse.** We may disclose your health information to a person legally authorized to investigate a report that you have been abused, neglected, or have been denied your rights.
- **For public health and health oversight activities**. We will disclose your health information when we are required to collect information about disease or injury, for public health investigations, or to report vital statistics.
- **To comply with legal requirements.** We may disclose your health information to an employee or agent of a doctor or other professional who is treating you, to comply with statutory, licensing, or accreditation requirements, as long as your information is protected and is not disclosed for any other reason.
- **For purposes relating to death.** If you die, we may disclose health information about you to your personal representative and to coroners or medical examiners to identify you or determine the cause of death. We may also disclose information about you for burial purposes, including grave marker inscription, unless you tell us not to.
- **To a correctional institution**. If you are in the custody of a correctional institution, we may disclose your health information to the institution in order to provide health care to you.
- **If you are in the criminal justice system,** we may disclose your health information to other state agencies involved in your treatment, rehabilitation, or supervision.
- **In judicial and administrative proceedings.** We may disclose your health information in any criminal or civil proceeding if a court or administrative judge has issued an order or subpoena that requires us to disclose it. Some types of court or administrative proceedings where we may disclose your health information are:
- **Commitment proceedings** for involuntary commitment for court-ordered treatment or services.
- **Court-ordered examinations** for a mental or emotional condition or disorder.
- **Proceedings regarding abuse or neglect** of a resident of an institution.
- **For national security**. We will disclose your health information if necessary for national security and intelligence activities, and to protect the president of the United States.
- **If you are also being treated for alcohol or drug abuse, FTA will not tell any unauthorized person outside of FTA that you are being treated for alcohol or drug abuse, without your written permission. We will not disclose any information identifying you as an alcohol, drug, or substance user, except as allowed by law.**

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;

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- To report suspected child abuse or neglect;
- Federal and State laws prohibit re-disclosure of information about alcohol or drug abuse treatment without your permission.
- Federal rules restrict any use of information about alcohol or drug abuse treatment to criminally investigate or 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 907-452-2473.

Signature of Client _____ Date: _____

Witness _____ Date: _____

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Court/LEGAL FEE AGREEMENT

- If you become involved in any litigation and an employee of LEAP, Alternatives to Violence has to appear in Court, write a report, or give testimony telephonically, the following will apply:
- There will be a fee of $350 per hour/per employee, with a 1 hour minimum.
- The fee will apply whether the employee testifies in person or telephonically.
- The hourly fee applies from the time the employee is subpoenaed to appear in court to the time the court releases them.
- There is a fee of $175 per hour for any time required to produce a written report, attorney contact, trial/hearing preparation, collateral contact, document review etc.

Clients are expected to pay a $350 deposit prior to the scheduled court date and pay any balance due within 10 days of the court appearance. If the court date is canceled less than 24 hours in advance a $50 fee will be charged.

Client Name: _____

Attorney: _____

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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Consent to Treat a Minor

I, give my permission to _____ to **(Parent/Guardian)** **(Counselor) see** my child for counseling or assessment, with or _____ **(name of minor child)** without my presence during sessions **(initial_____).** I understand that I have the right to control the disclosure of private counseling information about my child. However in the interest of resolving the issues we have brought to the counselor, I give the counselor permission to reveal to or withhold from me or others information that, in the counselor's judgment, is necessary to best help and protect my child **(initial_____).** Beyond my signing an *Authorization for Release of Protected Health Information,* the only exception to this would be in the case of:

_____

(Parent/guardian should write "not applicable" in the previous space if appropriate)
My signature below asserts and confirms my legal authority to sign on behalf of the minor

Parent/Guardian _____ Date _____

Counselor _____ Date _____

Fairbanks Therapy Associates Inc.
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Therapy Intake Child/Adolescent

Child's Name: _____ Date of Birth: _____ Age: _____
Child's Address: _____ Home Phone: _____
Child lives with: Both biological parents ____ Mother ____ Father ____ Mother & Stepfather _____
Father & Stepmother ____ Other (specify): _____
If parents are divorced, describe custody arrangements: _____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name: _____ Age: _____ Race: _____
Employer: _____ Occupation: _____ Hrs/wk: _____
Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____ Ext. _____
Religious Denomination: _____ Church: _____
Member? Yes ☐ No ☐ Active? Yes ☐ No ☐
Describe any physical problems you have that require medication or physical care:

Are you currently receiving medical treatment? Yes _____ No _____ Physician: _____
Medication(s) currently using:

Previous Counseling/Therapy? Yes _____ No _____ If yes, when? _____
With whom and for how long?

INFORMATION ABOUT CHILD'S FATHER:

Father's Name: _____ Age: _____ Race: _____
Employer: _____ Occupation: _____ Hrs/wk: _____
Employer's Address:

Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____ Ext. _____
Religious Denomination: _____ Church: _____
Member? Yes ☐ No ☐ Active? Yes ☐ No ☐
Describe any physical problems you have that require medication or physical care:

Are you currently receiving medical treatment? Yes _____ No _____ Physician: _____
Medication(s) currently using:

Previous Counseling/Therapy? Yes _____ No _____ If yes, when? _____
With whom and for how long?

FAMILY MEMBERS:

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:
Name - Relationship to Child - Age - Highest School Grade Completed - Occupation

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Using the scale below, please indicate choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.

_____ Anger/Temper _____ Talks of Suicide _____ Depression _____ Unhappy Most of the Time
_____ Divorce/Separation of Parents _____ Use of Alcohol_____ Adjustment to Parent's Remarriage
_____ Use of Other Drugs _____ School Performance _____ Work _____ Family Problems _____ Worry
_____ Fearfulness _____ Self-esteem _____ Physical Problems _____ Poor Appetite
_____ Problems with Social Relationships _____ Overeating _____ Problems Sleeping _____ Bedwetting
_____ Sexual Concerns _____ Soiling _____ Religious/Spiritual Concerns _____ Cruelty to Animals
_____ Nightmares _____ Other (specify): _____

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations? Yes ____ No ____
If yes, please list names, addresses, and dates of contact:_____

Has child had previous counseling? Yes _____ No _____ If yes, list names(s) of counselor(s), addresses, and dates of contact(s):_____

Reason for contact:

MEDICAL HISTORY:

Where her any complications surrounding the child's birth? Yes _____ No _____ If yes, describe:_____

List child's sicknesses, operation, and injuries. Indicate age when occurred, and describe how severe. Pleas pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

_____ List current medical problems: _____

Is child currently taking any prescription drugs? Yes _____ No _____ If yes, please list: _____

When did your child last have a physical examination?_____
Name of Physician: _____ Address: _____

How is the child's vision? _____ Hearing? _____

ACADEMIC/SCHOOL INFORMATION:

Name of school: _____ Grade: _____ Teacher: _____
List previous schools attended with dates:

Has child ever repeated a grade? _____ If so, which one(s)? _____
How does your child get along at school?

Describe difficulties in learning at school:

Have other family members have learning difficulties?

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Describe what your child likes to do for fun, special interests, hobbies, etc.

Describe your child's religious background (religious denomination is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.):

Anything else you think would be important for the counselor to know:

Any allergies or health issues or hospitalizations:

Has there ever been any involvement with OCS? _____ if yes, please explain:

Custodial Parent/Guardian: _____ Date: _____

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PLEASE COMPLETE THE FOLLOWING: (To be completed by child/adolescent)

1. I would like

2. If I were older

3. Girls

4. My friends think

5. What makes me mad is

6. My father

7. I miss

8. I am scared

9. I often think of myself as

10. My only trouble

11. I dream of

12. Being younger would

13. I hate

14. If I don't get what I want at home

15. What worries me is

16. When I grow up

17. Nothing bothers me more than

18. Other people think I'm

19. I feel unhappy sometimes because

20. Boys

21. There are times when I

22. Being my age is

23. I don't think I can

24. It's tough when

25. At home

26. Teachers are

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27. If I am left behind

28. Sometimes I think about

29. If I were smarter

30. Sometimes I feel like

31. It is more important to

32. I wonder if I should

33. My mother

34. If my parents had only

35. I would be happier if

36. I'm glad I'm

37. I wish I were

38. If I could choose my family

39. If only I were not so

40. It would be funny if

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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

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.

Fairbanks Therapy Associates Inc.

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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 Investigators (CCI)
_____ Child Support Enforcement (CSED)
_____ 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)
_____ Resource Center for Parents & Children (RCPC)
_____ Tanana Chiefs Conference (TCC)

_____ Other: _____

I authorize confidential information to be released from:

_____

to Fairbanks Therapy Associates Inc. (FTA) formerly known as LEAP Inc. 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

_____ _____
Witness Date

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 further 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 rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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