SUMMIT
COUNSELING SERVICES

Today's Date: _____

Name:	Date of Birth:
SSN:	Phone:
Email:	
Physical Address: _____ _____ _____	Mailing Address (if different) _____ _____ _____

Name of Person Responsible for Payment (Check this box if same as person listed above ☐)

If different please list below:

Name:	Their Phone:
Their DOB:	
Their Address: _____ _____ _____	

Client Rights/Informed Consent

CLIENT RIGHTS: As a consumer of services of Summit Counseling Services, you have the right:

1) To be treated with respect and dignity in a culturally sensitive manner
2) To be informed of eligibility criteria for the service in which you participate
3) To receive assistance with any communication barriers which make it difficult for you to receive services
4) To be free from discrimination while receiving services
5) To have access to your file according to federal/state/agency regulations and standards
6) To terminate services at any time
7) To be free from exploitation for the benefit or advantage of a staff member
8) To report complaints/grievances using the agency guidelines provided to you
   (Grievance forms are available on our website, or upon request at any Summit location reception desk)
9) To confidentiality as defined by policy and law. Summit Counseling Services maintains a strict policy on confidentiality of information (verbal, written, or electronic form). All information you share, or which we become aware of through our work with you will remain confidential. (According to state and federal statutes, Addiction records 42CFR Part 2) There are some circumstances in which this policy becomes void and we are required by law to release information:
   - If we become aware that you may be a danger to yourself or others
   - If we become aware of or suspect child abuse or neglect or vulnerable adult abuse and/or neglect
   - If we become aware of a medical emergency
   - If we are court ordered to testify or to submit our records to the court
   - If we become aware you have intent to commit a crime
   - According to State and National Ethic Policies if you are a third-party person sitting in on another client's session(s), you do not have the expectation of confidentiality. Confidentiality is afforded to the identified client only.
   - If a request is made by Homeland Security through the Patriot Act for information, your confidentiality is not protected.

SUMMIT'S EXPECTATIONS: As Summit Counseling Services provides services, it is expected:

l) That clients will be present and on time for appointments.

2) **Rescheduling or cancellations must be 24 hours in advance of appointment or appointment will be automatically billed to client at full billing rate of session.**
3) That clients will participate in service planning
4) That clients will not exhibit abusive threatening, or assaultive behavior
5) The clients will not be under the influence of chemicals during services
6) That clients will respect and protect the privacy of other client's information of which they may become aware

Summit Counseling Services reserves the right to deny services based on the above criteria.

INFORMED CONSENT: Informed consent is a process throughout the service relationship where discussion occurs between client and service providers. Clients have opportunities to ask questions in order to understand options available to them, consequences of different choices, and how the organization can help them achieve their choices. The following are components of informed consent:

1) Fees and payments
2) Staff qualifications, training, experience, credentials and Professional Statements, if applicable;
3) The types of services to be provided, expected length of services, results of any tests/assessments;
4) Risks, benefits and alternatives to service;
5) Range of services available through Summit Counseling Services;
6) Your active participation in your service plan with freedom to revise goals throughout service;
7) Possible outcomes of service;
8) Procedure for case closure

Summit Counseling Services is a training agency and participates with multiple colleges to assist in the training of their students. From time to time, students are required to share minimal information with their supervisors in order to benefit their educational opportunities and training.

Summit Counseling Services Operates as a Community Behavioral Health Clinic. We are not trained as experts. It is for this reason we will not write letters of recommendation, testify in child custody disputes, divorce cases, or other civil litigation.

1 HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTAND THE ABOVE INFORMATION.

Client Signature _____ Date _____

Parent/Guardian signature _____ Date _____

Witness/Staff presenting information _____ Date _____

☐ Client was offered a copy of this document

Technology Waiver

Communication by Email, Text Message, or Video Conferencing

It may become beneficial during your treatment to communicate using technology. At the present time SUMMIT COUNSELING SERVICE Inc. utilizes Microsoft Teams software and has been assured that their conferencing systems meet the criteria to maintain confidentiality according to federal statute 42 CFR, Part 2 and HIPPA confidentiality requirements. As a policy practice, we work hard to ensure that all communication with patients and/or families via technology is secure.

CONSENT FOR TRANSMISSION OF PREOTECTED HEALTH/ADDICTION INFORMATION BY SECURE/NON-SECURE MEANS

I consent to allow you to use secure/non-secure technology to transmit to me protected health information:

- Information related to scheduling of meetings and appointments
- Information related to referral sources
- Information related to evaluation, assessment, and programming

I have been informed of the risk, including but not limited to my confidentiality in treatment, of transmitting my protected health/addiction information by secure/unsecured means. I understand that I am not required to sign this agreement in order to receive treatment, however it may limit my treatment options in regard to accessibility. I also understand that I may terminate this consent at any time. **The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.**

_____ _____

Signature of Client Date

_____ _____

Witness Date

Authorization for Release of Information to Insurance Company

I authorize Summit Counseling Services and all business partners to release billing information which may include client name, date, type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of collecting insurance benefits or for authorization of additional sessions for:

Client Name: _____

Date of Birth: _____

Address: _____

Phone: _____

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Brenda Owen.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following your last appointment, unless otherwise restricted.
- **NO SHOW OR LATE CANCELLATION FEES WILL BE THE SOLE RESPONSIBILITY OF THE CLIENT**

Insurance Carrier— Name and Date of Birth	
Insurance Company-	
Insurance company address:	
Insurance Company Phone Number:	
Policy Number:	
Group Number if applicable	
Date coverage started if listed on card	
Co pay listed on card	

Although your insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental health benefits may differ from your medical benefits, so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will he responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees**. The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.**

Insurance Carrier: _____

Carrier's Relationship to Client: _____

Carrier's Place of Employment: _____

Carrier's Date of Birth: _____

Carrier's Phone: _____

Signature: _____ Date: _____

SUMMIT
COUNSELING SERVICES

PHONE 701-751-0299 FAX: 701-713-3299

Grievance Process: If at any time a client has an issue or concern with a staff member infringing on their rights, they are encouraged to first to attempt to address this issue with the person with whom the infringement allegedly took place with. If the client is unable to get satisfaction, clients are encouraged to fill out the grievance form provided online on Summit Counseling Services website, or in all offices utilized by Summit Counseling Services, or from any staff person that provides services for Summit Counseling Services, and submit it to the owner/operator of Summit Counseling Services. Clients will be appraised of their right to file a grievance with the Boards of Addiction, Counseling Examiners North Dakota Board of Counseling Examiners, and North Dakota Board of Social Work Examiners. They will be provided with the telephone numbers, web site information and/or address of the appropriate board/or boards.

- Summit Counseling Services shall protect the fundamental human, civil, constitutional and statutory rights of each client
- As appropriate Summit Counseling Services shall inform the client, the client's family or the client's legal guardian of their status as authorized by the client who is 14 years or older.
- Summit Counseling Services shall evaluate to ensure no restrictions were placed on the rights of individual clients and shall document in the clinical records the clinical rationale for, such restrictions.
- Grievances must be investigated and addressed by the owner/operator of the agency within 20 working days of receipt of grievance. Should the client believe that the grievance was not addressed appropriately they will be referred to the appropriate State Licensing Agency Board for resolution.

3111 E. Broadway Ave, Bismarck ND 58501

26 1st St E, Dickinson ND, 58601

(Administrative Office) 1500 14th St W Suite 290, Williston ND 58801

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Today's Date: _____

Name:	Date of Birth:
SSN:	Phone:
Email:	
Physical Address: _____ _____ _____	Mailing Address (if different) _____ _____ _____

Name of Person Responsible for Payment (Check this box if same as person listed above ☐)

If different please list below:

Name:	Their Phone:
Their DOB:	
Their Address: _____ _____ _____	

Child/Adolescent Bio-Psychosocial Assessment

(for parent and/or child/adolescent to complete)

Today's Date:_____ Child's Name:_____

Child's Age_____ Date of Birth:_____ School Child Attends: _____

School Release Signed? ☐Yes ☐No Current Grade in School _____

Mother/Step Parent Name & Address:	Father/Step parent Name & Address:
Phone #:	Phone #:
Primary Custody? ☐Yes ☐ No	Primary Custody? ☐ Yes ☐ No
Other Guardian? ☐ Yes ☐ No, If yes Name, Address & Phone:	

Custody Arrangements: ☐Yes ☐No If Yes, please indicate current arrangement: (Joint, Which parent has primary custody, any stipulations with custody agreement, etc) Please also provide a copy of the court order if applicable:

_____
_____
_____
_____

Top 3 Concerns/Reasons for Seeking Services: (Please note when these concerns first started for your child , ex: age 3 after attending a friend's birthday party)

1. _____
   _____
   _____
   _____
2. _____
   _____
   _____
   _____
3. _____
   _____
   _____
   _____

Who resides in the home? (Please list names/ages/relationship to the child). Any Pets? Parents/Guardians- What is your occupation?_____
_____
_____
_____
_____

How does everyone get along?_____
_____
_____
_____

Here is a list of **common symptoms** – please indicate those that concern you about your child.

☐Depressed/Sad	☐Withdrawn	☐Low Self Esteem	☐Loss of Interests	☐Self-Injurious Behaviors
☐Poor Sleep	☐Nightmares	☐Poor Social Skills	☐Defiant	☐Uncooperative
☐Anger Problems	☐Aggression	☐Drug Use	☐Alcohol Use	☐Over Sexualized Behaviors
☐Poor Self control	☐Hyperactivity	☐Inattentive	☐Poor Focus	☐Destruction of Property
☐Excessive Fears	☐Worry	☐Bedwetting	☐Fecal Soiling	☐Involuntary Urination
☐Hallucinations	☐Delusions	☐Dissociations	☐Regressive Traits	☐Lying
☐Immaturity	☐Academic Issues	☐Appetite Changes	☐Physical Complaints	

☐Other: _____
_____
_____
_____

Has your child ever had counseling before? ☐Yes ☐No If Yes, Where and When? _____
_____

Any psychiatric hospitalizations? ☐Yes ☐No If Yes please note where and the dates of service: _____
_____
_____
_____

Any involvement in the legal system? ☐Yes ☐No On probation? ☐Yes ☐No If yes, please explain below:
_____
_____

Family Dynamics: Family History of Mental Health Concerns:
_____
_____
_____
_____
_____

Family History of Drug/Alcohol Concerns: _____
_____
_____
_____

Parenting Who typically disciplines the child? _____

How does that discipline typically look in your household? (Check all that apply)

☐Remove Privileges	☐Add Chores	☐Yell/Scream/Shout	☐Lecture
☐Time Out	☐Ignore	☐Discuss Situation with Child	☐Spank with Hand
☐Spank with Object	☐Send to Room (alone)	☐Grounding	

☐Other: _____

Are you consistent with your discipline? ☐Yes ☐No Any Difficulties with providing discipline? ☐Yes ☐No If yes, please explain why it is difficult to discipline: _____
_____

How does your child typically respond when disciplined? _____
_____
_____

Risk Assessment:

Has your child ever had thoughts of harming his/herself? ☐Yes ☐No If Yes- please answer the following:

Has your child had a plan to do so? ☐Yes ☐No

Has your child ever attempted to harm his/herself? ☐Yes ☐No

Has your child attempted to harm others? ☐Yes ☐No If yes how so? _____
_____
_____

Has your child ever intentionally harmed an animal/pet? ☐Yes ☐No If so what happened? _____
_____
_____

Have you called the Crisis Line or any Crisis Interventions for your child? ☐Yes ☐No If Yes, please explain: _____
_____
_____
_____

History of Substance Use/Abuse

Has your child used/are using the following (add other info as needed):

☐Alcohol	☐OTC	☐Inhalants	☐Cocaine
☐Caffeine	☐Rx Med Abuse	☐Heroin/opiates	☐Synthetic/Club Drugs
☐Marijuana	☐Cigarettes	☐Hallucinogens	☐Meth

☐Other: _____

Received any drug/alcohol assessments or treatment? ☐Yes ☐No

If yes Where? _____ When? _____

Medical Information

Is your child currently on any medications? ☐Yes ☐No If yes please list below and who prescribes:
_____
_____

Please list any current medical issues, allergies, history of medical hospitalizations for medical issues or any histories of head injuries: _____
_____
_____

How was the pregnancy/delivery with the child? Any complications? Time spent in the NICU? Ongoing medical issues as a result? _____

_____

Developmental Milestones: (Please note if your child was on time, delayed or early)

Speaking: ☐on time ☐early ☐delayed (at what age?) _____

Walking: ☐on time ☐early ☐delayed (at what age?) _____

Potty Trained: ☐on time ☐early ☐delayed (at what age?) _____

Females- menstruating? ☐Yes ☐No Age at first period_____

Any ongoing issues with bathroom/bedwetting? ☐Yes ☐No If yes please describe below:

_____

_____

Trauma History

Below is a list of common stressors for children. Please indicate if your child has experienced any of the following and feel free to elaborate:

☐Sexual Abuse	☐Physical Abuse	☐Neglect
☐Emotional Abuse or Neglect	☐Witness to Domestic Violence	☐Sudden Loss of Family Member or Pet
☐Frequent Moving/Homelessness	☐Abandonment	☐Incarcerated Family Member
☐Alcohol/Drug Abuser in Household	☐Grief/Bereavement	☐Witness to Community Violence
☐Household member with Serious/Chronic Mental Health Issues		☐Life Threatening Experience

☐Other: _____

_____

_____

School History

Please note any issues experienced in the school setting (examples include: grades changing drastically, behavioral concerns at school, social difficulty, bullying, etc)

_____

_____

_____

_____

Is your child involved in any extracurricular activities either inside of school, church or outside of the school setting? (sports, music, clubs, youth groups, employed, etc.)

_____

_____

_____

What technology does your child have current access to? Please indicate those that apply:

☐Smart Phone	☐Computer w/Internet	☐IPAD/Tablet w/internet	☐Facebook Account
☐Twitter Account	☐Instagram Account	☐Snap Chat Account	☐Video Game

If video games, which ones? _____

_____

Other: _____

How is this technology monitored in your home? _____
_____

Do you have password access? _____ How does your child primarily communicate with their friends?
_____
_____

Have there been any issues with your child being bullied or bullying others online? ☐ Yes ☐ No If yes, please explain:
_____
_____

Any other online issues? (Communicating with strangers, etc) ☐ Yes ☐ No If yes – please describe:
_____
_____

Additional Supports: Please make note of any additional supports your child has in his/her life that they have regular access to (grandparents, other family members, best friends, coaches, youth advisors, etc)
_____
_____
_____
_____

Strengths Please tell us some of your child's biggest strengths. What are the best things about him/her?
_____
_____
_____
_____

What are his/her favorite things to do for fun? _____
_____
_____

Is there anything else you would like us to know about your child?
_____
_____
_____
_____

Please stop here- the remaining part of the assessment form is for your therapist to complete.

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

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

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**