YOUTH & FAMILY SERVICES
OF HADDAM-KILLINGWORTH INC.
Strong families equal strong communities

Youth & Family Services of Haddam-Killingworth, Inc.

DATE _____ **REFERRAL SOURCE** (AGENCY/PERSON) _____

ADDRESS _____ PHONE _____

EMAIL ADDRESS _____

CLIENT'S NAME _____ DOB_____

GENDER IDENTITY _____ AGE _____ RACE _____ ETHNICITY _____

IF STUDENT, CURRENT GRADE LEVEL _____

ADDRESS _____

HOME PHONE (_____) _____ MOBILE PHONE (_____) _____

NAME(s) of PARENT(s)/GUARDIAN(s): _____

ADDRESS 1: _____

ADDRESS 2 (IF APPLICABLE): _____

MOBILE PHONE (_____) _____ HOME PHONE (_____) _____

OTHER PHONE (_____) _____ EMAIL(s) _____

IF DIVORCED/SEPARATED, CUSTODY STATUS: _____
(Printed copy of court documentation is REQUIRED)

☐ CHECK BOX IF OKAY TO LEAVE VOICEMAILS

☐ CHECK BOX IF EMAILS ARE OKAY FOR SCHEDULING PURPOSES & APPOINTMENT REMINDERS

EMERGENCY CONTACT _____

HOME PHONE (_____) _____ WORK HOME (_____) _____

REASON(S) FOR REFERRAL (CHECK ALL THAT APPLY)

☐ PARENT SUPPORT ☐ INDIVIDUAL THERAPY ☐ FAMILY THERAPY ☐ COUPLES THERAPY

☐ JUVENILE REVIEW BOARD ☐ COURT MANDATED ☐ GROUP THERAPY

BRIEF DESCRIPTION OF PROBLEM
(ATTACH SEPARATE SHEET IF NECESSARY. PLEASE FORWARD MEDICAL & BEHAVIORAL INFORMATION, COURT REPORTS, SOCIAL SUMMARIES, PREVIOUS EVALUATIONS, ETC.)

_____
_____
_____
_____
_____

I, _____, hereby authorize Youth & Family Services of Haddam-Killingworth, Inc. (hereinafter referred to as HKYFS) to bill my/my child's health/behavioral health insurance carrier(s) for the services rendered to my child/family by the agency. I hereby give my consent to HKYFS to release medical and other relevant information to my/our insurance carrier as required by my/our insurance carrier to process medical billing.

By signing my signature below, I agree to pay HKYFS any deductible, co-pay, or uncovered charge in accordance with my health care plan. I accept financial responsibility for any claims that are not reimbursed by my insurance carrier.

Name of Primary Health Insurance Co. _____

Member Number _____ Group Number _____

Name of Secondary Health Insurance Co. _____

Member Number _____ Group Number _____

Co-pay amount client is responsible for per session $ _____

_____ _____
Printed Name of Client Date

_____ _____
Signature of client or parent/guardian Relationship to client

_____ _____
Signature of Staff Date

STATISTICAL DATA:
(check all that apply)

Family Constellation:
__ Two birth/adoptive parents
__ Step ad birth parent
__ Single parent (female)
__ Single parent (male)
__ Grandparents
__ Relative/Guardian
__ DCF Guardianship
__ Foster parent(s)
__ On own
__ Joint Custody
__ Other

Referral Source:
__ Police
__ School
__ Parent/Guardian
__ DCF
__ Superior Court, juvenile matters
__ Social Services Agency
__ JRB
__ Self
__ Other

Homeless:
__ Not Homeless
__ Homeless Shelter
__ Sharing Housing
__ Unsheltered
__ Hotel/Motel
__ Unaccompanied Youth

Demographics:
Hispanic:
__ Yes
__ No
__ Unknown

Race:
__ White
__ Black/African American
__ American Indian or Alaskan
__ American Indian or Alaskan
__ Multiracial
__ Asian
__ Native Hawaiian or Other Pacific Island
__ Other

Reason for Referral (up to 4):
__ Positive Youth Development
__ Delinquent Behavior
__ Truancy from school
__ Defiance of School Rules
__ Indecent/Immoral conduct
__ Running Away
__ Beyond Control
__ Non-school Issue

Special Issues:
__ Depression
__ Suicidal Behavior
__ Sexual/physical abuse/neglect
__ Bullying
__ Substance Abuse
__ Pregnancy/teen parent
__ Homelessness/at risk of
__ Parenting/Family Issues
__ School Issues
__ Internet Related
__ Dating Violence

Additional Special Issues:
__ Eating Issues
__ Anxiety
__ Self Injury

Youth & Family Services of Haddam-Killingworth, Inc.
P.O. Box 432
Higganum, CT 06441
(860) 345-7498

Welcome to Youth & Family Services of HK, Inc. (YFSHK). We are a private, non-profit counseling and social service agency servicing youth and their families. As this may be your first time in counseling, we have outlined some areas to introduce you to our counseling program. We hope your experience will be positive and rewarding.

Assessment
The initial counseling sessions will be important to gather information and mutually identify concerns to establish a treatment plan. You and your family may attend these sessions to assist the counselor in gaining a complete perspective. You may be asked to sign a release of information which will enable us to better coordinate your treatment. Here at YFSHK we firmly emphasize the creation of a genuine therapeutic relationship between therapist and client to allow for optimal growth. This relationship is paramount in the success of the mutually agreed upon treatment. The assessment period will also determine if YFSHK is the best fit for the client's needs and goals. If in fact YFSHK is mutually agreed upon as not the best fit, we will ensure an appropriate transition to an additional agency or counselor.

Counseling
Successful counseling involves individuals and families or groups of people looking at the blocked areas in their lives, understanding the causes and influences of these perceived blocks and then taking action to resolve the issues that are troubling/blocking them. For counseling to be the most effective, we ask that you actively participate in the counseling process by honestly presenting your blocks, observations and perceived influence over these presented issues. It is important to work on blocks in your daily life, not only during sessions and make every effort to follow recommendations with which you are in agreement.

Our agency provides short term counseling services. You and your counselor will periodically review your progress and plan for continued services if appropriate. Clients with more long-term counseling needs can be referred to other agencies and/or services if deemed necessary.

Confidentiality
Youth and Family Services comply with a Professional Code of Ethics; therefore, all sessions and information will remain confidential. Please understand that the law may require mandated reporting and that reporting is required when safety is an issue.

Termination of Counseling
When you and your counselor agree that you have met your desired goals of treatment you may wish to stop counseling. It is important to discuss your needs with your counselor, as how the counseling ends, is an important phase of the counseling process. Your input is critical to the termination of services. HKYFS adheres to the accepted practice of record retention. Upon terminating, records will remain with this office until state law allows records to be destroyed.

Fees
Youth and Family Services is a non-profit agency. We are able to offer services at reasonable rates. Payments are important to our agency as they directly support our counseling services. Payment is expected at the end of each session. Fees are determined using a sliding scale based on the client's ability to pay.

Appointments

Appointments are 50 minutes. We kindly ask for 24 hours advance notice for cancellations. **If you miss your scheduled appointment without notifying the agency you will be charged $40.00.** If you miss three or more consecutively scheduled sessions without notification, we will assume you are no longer able to participate in active treatment and will be placed back on the waiting list or will be referred to another provider. It is important to comply with this request to accommodate those who are waiting for services.

We want your experience to be a fulfilling one. If at any time you have concerns or questions about the services you are receiving, please talk directly to your counselor. The Agency Director is always available in the event you have additional concerns.

I have reviewed the above with my counselor: _____ Date_____

_____ _____
Client/Guardian Signature #1 Date

_____ _____
Client/Guardian Signature #2 Date

YOUTH & FAMILY SERVICES
OF HADDAM-KILLINGWORTH INC.
Strong families equal strong communities

91 Little City Road, P.O. Box 432, Higganum, CT 06441
(860) 345-7498
www.hkyfs.org

Consent to Treatment

I, (name of client or minor child) _____, voluntarily consent to be treated by the therapist I have chosen or that I have been assigned to work with in therapy. I affirm that I have been given no guarantees as to the result which will be obtained through treatment, although it is generally recommended that I remain in therapy until the goals that my therapist and I mutually agreed upon have been substantially achieved.

I also understand that I may leave treatment at any time by my own decision. Unless otherwise specified, this authorization and consent will expire on the date that I am discharged from treatment.

This authorization may be withdrawn by me at any time by notifying my therapist.

Confidentiality

Confidentiality and privileged communications are rights of all clients of psychiatrists and other mental health clinicians according to the law and professional ethics. No information about you, or the psychiatric or counseling services provided to you, will be released without your permission. Here are, however, certain exceptional circumstances in which a psychiatrist or therapist may be required by law to breach confidentiality.

1. If a court of law issues a legitimate subpoena, then we are required to provide the information specifically described in the subpoena.
2. If you indicate that you intend to harm or kill yourself or someone else, then we must act to notify potential helpers or victims if we believe that there is a real and imminent danger.
3. If you report, or we suspect, that you are an active perpetrator or victim of child abuse or molestation, we are obligated to report this to the authorities.
4. If you are in psychotherapy and/or being evaluated by order of a court of law, the results of the evaluation and/or treatment may be revealed to your probation officer or the court.
5. If you are a minor, your parents or guardians must be informed of your progress, if they ask. However, they do not have to be told all details of your conversations.

Every effort will be made to discuss with you a breach of confidentiality that is being considered and to resolve the issue to your satisfaction. If you have any questions about the above information, feel free to discuss them with your psychiatrist or therapist at any time.

I understand Youth & Family Services of Haddam-Killingworth, Inc. is not available 24 hours a day, although every effort will be made to reach a clinician in an emergency. I agree to notify my doctor or therapist in advance so that appropriate arrangements can be made if I think I might require 24 hour coverage. I also agree to contact, and talk to my doctor or therapist prior to any potential or imminent act of danger to others or myself.

I have read the above and understand the therapist's social, legal, and ethical responsibilities to make such decisions as necessary.

_____ _____

Signature of Client/Legal Guardian #1 Date

_____ _____

Signature of Client/Legal Guardian #2 Dates Date

Youth & Family Services of Haddam- Killingworth, Inc.
P.O. Box 432
91 Little City Road
Higganum, CT 06441
860-345-7498

Written Acknowledgement of Receipt of Privacy Practices
Written Acknowledgement of Receipt of Crisis Guidelines

Client Name: _____

Date of Birth: _____

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices and Crisis Guidelines. I understand that if I have further questions or complaints I may contact: YFSHK 860-345-7498.

I also understand that I am entitled to receive updates upon request if HKYFS's Notice of Privacy Practices or Crisis Guidelines are amended or changed in a material way.

_____ _____
Signature of Client/Parent/Guardian Signature of Client/Parent/Guardian

_____ _____
Relationship to Client Relationship to Client

_____ _____
Date Date

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On_____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices and Crisis Guidelines from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Agreement.

[ ] Patient did not understand the request to sign the Written Acknowledgement.

[ ] Other – Specify: _____

_____
Name and Title of employee

_____
Date

Youth & Family Services of Haddam- Killingworth, Inc.
P.O. Box 432
91 Little City Road
Higganum, CT 06441
860-345-7498

Crisis Guidelines

The following information provides guidelines for clients who find themselves thinking of being unsafe. These steps can help prevent tragedy in the event that you find your circumstances become so overwhelming that you find yourself thinking of hurting yourself or someone else.

- Call 911 and tell the operator of your location and that you are feeling unsafe.
- Call 211 and to request EMPS Services
- Go to the nearest hospital emergency room to have a mental health evaluation so that an immediate plan can be established to maintain your safety.
- You may attempt to contact your clinician by phone but please note that the clinicians here at YFSHK are **not** full time and are **not** on call 24 hours 7 days a week; therefore, we are unable to guarantee immediate care. You may leave a message for your clinician and they will make every effort to return your call as soon as possible.
- We encourage you to tell those individuals closest to you about your thoughts to ensure your physical and emotional safety at least until those feelings have been resolved.
- Attend all recommended medical and behavioral health appointments, and take any prescribed medications as directed. Work in close conjunction with medical and behavioral health providers to report symptoms, thoughts and side effects.
- Try to remember that these thoughts will pass and your outlook on life will continue to improve as you participate in treatment.
- In order for our agency to adhere to federal and state HIPPA laws, we will not engage in electronic communication regarding your case. If you need to contact your therapist, you may leave a confidential voicemail and your call will be returned on the therapist's next working day.

Youth & Family Services of Haddam-Killingworth, Inc.

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone with out written consent or other authorization as provided in the aforementioned statute.

I,_____ hereby authorize Youth & Family Services of
(Client/Guardians)

Haddam-Killingworth to receive and disperse information regarding _____
(Client/Date of Birth)

To be shared with:

Name:_____ Relation to Client:_____

Phone/Fax:_____

Address:_____

The information requested is listed below:

_____ 1. Diagnosis, brief description of progress and prognosis
_____ 2. Medical and physical history, laboratory tests
_____ 3. Discharge summary and aftercare recommendations
_____ 4. Psychological assessment sheets
_____ 5. Treatment plan
_____ 6. Psychological tests
_____ 7. Case assessment sheets
_____ 8. DCF history
_____ 9. Police/Juvenile Court Records
_____ 10. Financial need
_____ 11. School records, including _____
_____ 12. Other: _____

This information will be provided for the following reasons:

_____ 1. Coordination of services between involved agencies
_____ 2. Consideration of financial assistance
_____ 3. Aftercare planning
_____ 4. Other: _____

I understand that the records to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV- (AIDS) related information.

I understand that the above information is protected under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States code and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I need not consent to the release of information in order to obtain services.

I understand information once released from this office may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure.

I may withdraw this consent at any time prior to the release of information.
This consent, if not withdrawn, will expire on _____.
(Date)

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian #1 Date

_____ _____
Signature of Parent/Guardian #2 Dates Date

_____ _____
Signature of Witness Date

Youth & Family Services of Haddam- Killingworth, Inc.
P.O. Box 432
91 Little City Road
Higganum, CT 06441
860-345-7498

Counseling Fees

It is the policy of Youth & Family Services that clients receiving counseling pay a fee for their sessions.

- Initial Diagnostic Intake Rate $120.00
- Individual Therapy Session Rate $100.00
- Family Therapy Session Rate $100.00
- Couples Therapy Session Rate $100.00
- Group Therapy Rate $50.00

No one is refused services due to his or her inability to pay. In order to determine your counseling fee please fill out the following:

Household Income Worksheet

$_____Wages (before taxes) of adults living in the home
$_____ Other sources of Income (Unemployment, Child Support, Social Security, etc.)
$_____Total yearly Income

Below is our fee schedule. To determine your fee for counseling please:

- Circle your total yearly household income category
- Determine the number of members in your household
- Circle the fee that pertains to you on the chart below

Number of Family Members

GROSS ANNUAL INCOME	1	2	3	4	5	6
$0 - 21,660	10	10	10	10	10	10
$21,661 - 32,480	25	20	15	10	10	10
$32,481 - 37,890	35	30	25	20	15	10
$37,891 - 43,230	45	40	40	30	25	25
$34,231 - 58,220	60	55	50	40	30	20
$58,221 - 73,240	70	70	60	50	40	30
$73,241 - 88,200	80	80	70	60	50	40
$88,201 - 103,161	90	90	80	70	60	50

Please note the following:
If you cannot afford the listed fee, a further reduction may be possible with the approval of the Executive Director. Please discuss this with your counselor. **Please note that a $40.00 fee will be charged for appointments cancelled less than 24 hours in advance. This Policy can be altered at the discretion of the Clinical Director. All no showed appointments will automatically receive the $40.00 fee.**

Fee per Session (to be filled in by clinician): _____

Client Name (printed) _____

Client/Guardian #1 Signature_____

Client/Guardian #2 Signature_____

Counselor Name_____

Counselor Signature_____

Executive Director Signature_____ Date: _____