Center for Child & Family Services, Inc.
2021 Cunningham Dr.
Hampton, VA. 23666

Group Assignment ____________
Start Date ____________

Intake Packet Behavioral Health Services

Today's Date: ____________

Client's First Name ____________ Last Name ____________ MI ______

If client is a dependent: Name of mother: ____________ Check if child resides with you ____
Name of father: ____________ Check if child resides with you ____
Name of Guardian (if different from above): ____________
Street Address ____________ City ____________ Zip ______
Home phone ____________ **Cell Phone** ____________ May we leave a message for you at home/cell? □Yes □No
Work phone ____________ May we leave a message for you at the office? □Yes □No

Employment status: □ Employed full time □ Part time employee □ Not employed □ Retired □ Student
Employer/School: ____________ Position/Grade: ____________

Date of birth ______ Gender: M F Marital Status: M S D Sep W SS# ____-____-____
Name of person referring you to us ____________ Organization ____________

Household income (annual) ____________ **Primary insurance company** ____________

Policy number ____________ Group number ____________
Name of insured ____________ Relationship to client ____________

Secondary insurance company ____________
Policy number ____________ Group number ____________
Name of insured ____________ Relationship to client ____________

Number of people in household: ______ Please list anyone who lives with you:

Name ______ Age ______ Relationship ______ Name ______ Age ______ Relationship ______

Name ______ Age ______ Relationship ______ Name ______ Age ______ Relationship ______

Name ______ Age ______ Relationship ______ Name ______ Age ______ Relationship ______

CCFS is a private nonprofit agency that receives funding from United Way and other community resources. We are required to track demographic information to ensure that we are meeting the needs of the community without discrimination. *This information will in no way affect the services you receive. Please check the one which applies to you:*

Ethnic group: □ White/Caucasian □ African American □ Asian American □ Hispanic □ Native American □ Other ____________

Disability: □ Mental □ Physical **Education:** □ some high school □ HS grad □ some college □GED □ BA/BS □ graduate school

Office use only: Program enrollment: (Child or Adult)
□ MHT □ PC □ SHOP □ PAST □CAN □ SAPP □ Launch
□ FS □ VP □HER □ FH □ YES □ SH □ BFree

Are you feeling suicidal? ○ Yes ○ No If so, how recently have you felt this way? ____________

Do you own a firearm? ○ Yes ○ No Are you currently under a protective order? ○ Yes ○ No

Do you have any chronic or past medical problems? If so, what are they?

____

Do any of the following apply to you? (please check all that apply)

- ○ Loss of appetite
- ○ Restless sleeping
- ○ Chronic tiredness
- ○ Trouble concentrating
- ○ Hopelessness
- ○ Risk-taking
- ○ Overeating
- ○ Repetitive behaviors
- ○ Unexplained memory gaps
- ○ Sleeping too much
- ○ Crying
- ○ Vomiting
- ○ Insomnia
- ○ Nightmares
- ○ Unexplained panic
- ○ Head injury
- ○ Memory loss
- ○ Hallucinations
- ○ Excessive anger
- ○ Anxiety

Do you drink alcohol, including beer and wine or take illegal drugs? ○ Yes ○ No

Have these substances caused problems for you in any of the following ways (check all that apply):

○Work ○Home ○School ○Health ○Legally

Did you reside with both parents growing up? ○Yes ○No

If no, how often did you get to see your noncustodial parent? ____________

Have you ever been hospitalized for mental/emotional and/or drug problems? ○Yes ○No

If yes, when and where? ____________

Have you ever received counseling services? ○Yes ○No

If yes, for what and how long? ____________

Please list any medications that you are currently taking.

Medication and Date Taking	Purpose	Dose & Frequency	Physician	Side Effects? If yes, describe

Center for Child & Family Services, Inc.
"About Our Fees"

Center for Child and Family Services (CCFS) is a non-profit, community service agency providing services to the Hampton Roads area. In order to enable persons to afford counseling, the hourly fees may be made via sliding scale fee, insurance coverage, and/or other support from United Way, grants, etc.

- The full fee for individual, family, or couples counseling is $84.00 for a 50-minute session. This fee is due at the time services are received. This fee is subject to change.
- A sliding scale fee is available for clients who cannot pay the full cost of service. The sliding scale fee is based on household gross income levels (before taxes) and number of persons in the family.
- Income levels must be verified by W-2s, the most recent tax return, or most recent payroll stubs. Failure to supply one of these will result in a FULL FEE CHARGE.
- If a client and counselor determine that additional time is needed beyond 50 minutes, then an additional charge will be made in 15 minute increments. If a session lasts longer than 90 minutes, then the fee will be doubled to $168.00.
- If you have insurance, we will process your claims on your behalf at our full fee rate of $84.00. The client is ultimately responsible for the fee and any balance not covered by insurance due to policy deductibles, co-payments, or invalid/incomplete insurance information.
- Appointment cancellations must be made 24 hours or more prior to the scheduled service, or a fee of up to the full amount ($15.00) will be charged. Insurance companies do not reimburse for missed appointments – it is the client's responsibility.
- If a client is 20 minutes or more late to an appointment, the appointment will be cancelled and the client will charged up to a $15.00 late fee.
- Any request to represent you in court may result in a charge of $300 that must be paid prior to court.
- There will be a $15 charge for any request for copies of records, case summary records or disability form completion. This must be paid before the service is provided.
- If I have a delinquent balance, I may be denied services until the account is current.
- My fee for a 50 minute session is $____________ and is due at the time I receive the service.

ACKNOWLEDGEMENT OF RECEIPT

I have had the opportunity to read or have had read to me this **fee agreement** and have had the opportunity to ask questions about it. I understand that my fee is $____________ for a 50-minute session and I am responsible for all fees as agreed herein.

________________________________ ________________

Client over 18/Guardian or Parent — Date

Center for Child & Family Services, Inc.
2021 Cunningham Drive, Suite 400
Hampton, Virginia 23666
757-838-1960

Privacy Notice
Effective Date: April 1, 2005
Update: January 29, 2008

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

- Center for Child & Family Services (CCFS) includes Behavioral Health Services, Peaceful Choices, Safe Harbor for Kids, Vision Point, Youth Employment Services, Consumer Credit Counseling Services of Hampton Roads, Child & Family Connection of Williamsburg, and CONTACT PENINSULA. As Center for Child & Family Services is used throughout this notice, it means Center for Child & Family Services as a whole and/or an individual agency (as in CCFS's YES Program).

- In this notice, "you" refers to you, your child, and/or your family.

CCFS understands that medical information about your health is personal. We are committed to maintaining the privacy of your protected health information ("PHI"), which includes your medical and/or mental health condition and the care and treatment you receive from CCFS. It may include family PHI as well. We create a record of the care and services you receive at CCFS. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice details how the PHI included in your record may be used and disclosed to third parties to carry out treatment, payment for your treatment, day-to-day business activities (health care operations as defined below) of CCFS, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our web site at www.kidsandfamilies.com or calling the CCFS Privacy Officer at (757) 838-1960 and requesting that a revised copy be sent to you in the mail, e-mail, fax or asking for one at the time of your next appointment.

USE OR DISCLOSURE OF PHI

Center for Child & Family Services may use and/or share your Protected Health Information (PHI) for treatment, payment for your treatment, and health care operations at CCFS. Your Protected Health Information may be used and shared by your service planner, other treatment team members and others outside of our agency that are involved in your care and treatment for the purpose of providing health care services to you.

1. The following are examples of the types of uses of and/or ways of sharing your information that may occur. These examples are not meant to include all possible types of use and/or disclosure.
   a) **Treatment** – In order to provide, arrange and manage your health care, CCFS will provide your information to other health care providers, on CCFS's staff or not, directly involved in your care so that they may understand your medical and/or mental health condition and needs and provide advice and/or treatment. For example, a mental health provider treating your child for a condition such as depression may need to know what medications have been prescribed for them by other health care providers at CCFS and/or in the community.

   b) **Payment** – Your information will be used, as needed, to obtain payment for services provided to you. CCFS will provide your information to billing services and to appropriate third party payers as required. For example, CCFS may need to provide Medicaid with information about the services you received from CCFS so CCFS can be paid.

   c) **Health Care Operations** (business activities)– We may use or share, as needed, your information in order to support the business activities and operations of CCFS as required by law and funded requirements as well as continuing the quality and efficient care to you. These activities include, but are not limited to, quality assessment activities, performance evaluations of CCFS employees, training of student interns, licensing, marketing and fundraising activities, credentialing/licensure surveys and conducting or arranging for other business activities.

AUTHORIZATION NOT REQUIRED

1. Center for Child & Family Services may use and/or share your information, without a written authorization from you, in the following instances:
   a) **De-identified Information** – Your information is changed so that it does not identify you. Information is removed as well (e.g., your name, address)

   b) **Business Associate** – To a business associate, who is someone CCFS contracts with to provide you with services, pays us for your treatment and our business activities (e.g., billing service or transcription service). CCFS will obtain written assurance, in accordance with applicable law; the business associate will protect your information.

   c) **Personal Representative** – To a person who, under law, has the authority to represent you in making health care decisions.

   d) **Public Health Activities** – Such activities may be information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

e) **Federal Drug Administration (FDA)** – As required by the FDA to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

f) **Abuse and/or Neglect** – To a government authority, CCFS is required by law to make such disclosure. CCFS will do so if it believes that sharing the information is necessary to prevent serious harm or if CCFS believes that you have been the victim of abuse and/or neglect. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

g) **Health Oversight Activities** – Such activities, required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

h) **Court and Administrative Proceeding** – CCFS may be required to share your information in response to a court order or subpoena.

i) **Law Enforcement Purposes** – In certain instances, your information may have to be shared with law enforcement for law enforcement/emergency purposes. Law enforcement purposes include:
   - Complying with a legal process (e.g., subpoena) or as required by law;
   - Information for identification and location purposes (e.g., suspect or missing person);
   - Information regarding a person who is or is suspected to be a crime victim;
   - In situations where the death of an individual may have resulted from criminal conduct;
   - In the event of a crime occurring on the premises of CCFS;
   - A medical emergency (not on CCFS's property) has occurred, and it appears that a crime has occurred;
   - A medical emergency occurring on CCFS's premises (e.g., Mental Hygiene Arrests or accident/injury);
   - To a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

j) **Avert a Threat to Health or Safety** – CCFS may share your information if it believes that sharing the information is necessary to prevent or lessen a serious and probable threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

k) **Specialized Government Functions** – CCFS may use information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. CCFS may also share your information to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

l) **Inmates** – CCFS may share your information to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your information is necessary to provide care and treatment to you or is necessary for the health and safety of other individual or inmates.

m) **Required by Law** – As required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

n) **Emergencies** – We may use or share your information in an emergency treatment situation. If treatment is required by law and the health care provider has attempted to obtain your consent but is unable to, they may still use or share your information for treatment.

o) **Communication Barriers** – We may use and share your information if your service planner or another CCFS staff tries to communicate for treatment purposes but is unable to do so due to communication barriers and the service planner or staff determines, using professional judgement, that you intend to authorize the use or share under the circumstances (e.g., language barriers where an interpreter is needed or hearing impairment).

p) **Sign in Sheets** – CCFS may use a sign-in-sheet at the registration desk. CCFS may also call your name in the waiting room when your service planner or physician is ready to see you.

q) **Appointment Reminders** – CCFS may, from time to time, contact you to provide appointment reminders.

r) **Treatment Alternatives/Benefits** – CCFS may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

s) **On-Call Coverage** – In order to provide on-call coverage for you, it is necessary that CCFS establish relationships with other organizations/agencies/health care providers who will take your calls after hours or if your service planner is not available. The on-call staff will provide CCFS with whatever PHI that they create and will, by agreement, keep your PHI confidential.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written authorization. You may cancel the authorization at any time, in writing, except to the extent that CCFS has taken an action in reliance on the use or disclosure indicated in the authorization.

MARKETING & FUNDRAISING
CCFS may only use and/or disclose your PHI for marketing activities if we obtain from you a prior written authorization. "Marketing" activities include communications to you that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. However, marketing does not include, for example, sending you a newsletter about CCFS.

FAMILY and/or FRIENDS
It is the policy of CCFS, as well as required by law, that we will not confirm or deny if someone is receiving or has received services by CCFS or any of its affiliates. In situations where someone is looking for you or your child, we will instruct them to contact you for that information.

CCFS may sponsor events (i.e., school functions, birthday parties, picnics, school photos) in which parents and/or significant family members may take photographs or videotapes of their children at the events. It is possible they may capture you in the photograph and/or videotape.

YOUR RIGHTS
You have the right to:

a) Cancel any authorization, in writing, at any time. To request a (cancellation) revocation, you must submit a written request to CCFS's Privacy Officer.

b) Request restrictions on certain use and/or share of your information as provided by law. To request restrictions, you must submit a written request to CCFS's Privacy Officer. In your written request, you must inform CCFS of:
   - What information you want to limit;
   - Whether you want to limit CCFS's use or disclosure, or both; and
   - To whom you want the limits to apply.

   CCFS is not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If we do agree to the requested restriction, we may not use or disclose your information in violation of that restriction unless it is needed to provide emergency treatment.

c) Have confidential communications or information by alternative means or at alternative locations. You can request that we contact you at alternate locations, contact you by e-mail or fax, etc. You must make your request in writing to CCFS's Privacy Officer. CCFS will accommodate all reasonable requests.

d) Review and copy your PHI as provided by law. To review and copy your information, you must submit a written request to CCFS's Privacy Officer. CCFS can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, CCFS may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

e) Correct your PHI as provided by law. To request a correction, you must submit a written request to CCFS's Privacy Officer. You must provide a reason that supports your request. CCFS may deny your request if:
   - It is not in writing;
   - If you do not provide a reason in support of your request;
   - If the information to be amended was not created by CCFS (unless the individual or entity that created the information is no longer available);
   - If the information is not part of your PHI maintained by CCFS;
   - If the information is not part of the information you would be permitted to inspect and copy; and/or
   - If the information is accurate and complete.

   If you disagree with CCFS's denial, you will have the right to submit a written statement of disagreement with us and we may prepare a response to your statement and will provide you with a copy of this.

f) Receive an accounting of who your information has been shared with, what was shared and when. This right applies to those purposes other than treatment, payment or business activities as described in this Notice of Privacy Practices. It does not include those times information was shared with you for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. To request an accounting, you must submit a written request to CCFS's Privacy Officer.

   The request must state:
   - A time period which may not be longer than six (6) years and may not include dates before April 14, 2003;
   - The request should indicate in what form you want the list (such as a paper or electronic copy).

   There will be no charge for the first list you request within a twelve (12) month period, but CCFS may charge you for the cost of providing additional lists. CCFS will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

g) Receive a paper copy of this Privacy Notice from CCFS upon request to CCFS's Privacy Officer.

h) Complain to CCFS or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with CCFS, you must contact CCFS's Privacy Officer. Complaints may be in writing or a phone call.

Consent Form

I understand that the Center for Child & Family Services will file insurance claims on my behalf. I also understand that I am ultimately responsible for this account and any balance not covered by my insurance or due to deductible amounts.

Signature of Client/Guardian or Parent

I authorize the release of any medical information necessary to process my insurance claims. This authorization shall remain valid until revoked in writing.

Signature of Client/Guardian or Parent

I authorize payment of medical benefits to my physician or therapist at the Center for Child & Family Services. This authorization shall remain valid until revoked in writing.

Signature of Client/Guardian or Parent

I have received and reviewed the Center for Child & Family Services policy for client rights and responsibilities.

Signature of Client over the age of 14 | Signature of Parent/Guardian | Date

I acknowledge that I have received a copy of the Privacy Notice for Center for Child & Family Services. By signing below, I hereby voluntarily and knowingly consent to allow CCFS and any of its counselors, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

Signature of Client over the age of 14 | Signature of Parent/Guardian | Date

If I am signing this for a minor, I confirm that I am the legal guardian for this child.

Signature of parent or guardian | Date

Center for Child & Family Services-Witness | Date