

**CUMBERLAND VALLEY COUNSELING ASSOCIATES**

**INITIAL CONTACT FORM**

**NAME:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
**Street Town State Zip**

**CIRCLE PREFERRED METHOD OF CONTACT**

**TELEPHONE:** \_\_\_\_\_  
**Home Work Cell**

**EMAIL ADDRESS:** \_\_\_\_\_

**REASON WHY YOU CALLED:** \_\_\_\_\_

**EMERGENCY CONTACT PERSON:** \_\_\_\_\_  
**Name Relationship Telephone Number**

**INSURANCE:**

**Primary:** \_\_\_\_\_  
**Insurance Company Policy Holder or Relation to Holder ID Number**

**Secondary:** \_\_\_\_\_  
**Insurance Company Policy Holder or Relation to Holder ID Number**

**EMPLOYER OF POLICY HOLDER:** \_\_\_\_\_

**How did you hear about our company?** \_\_\_\_\_



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NAME: \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_

EDUCATION/TRAINING:

Highest Level of Education: \_\_\_\_\_ High School \_\_\_\_\_ College \_\_\_\_\_ Graduate  
\_\_\_\_\_ Other Training/Certificates: \_\_\_\_\_

EMPLOYMENT HISTORY:

Are you currently employed? \_\_\_\_\_ No \_\_\_\_\_ Yes:  
If "Yes", employer is: \_\_\_\_\_ How long have you worked here? \_\_\_\_\_ years  
What do you do? \_\_\_\_\_  
Do you enjoy your work? \_\_\_\_\_ No \_\_\_\_\_ Yes Why do you like or dislike your work? \_\_\_\_\_

How many jobs have you had in the last: three years \_\_\_\_\_ five years \_\_\_\_\_ ten years \_\_\_\_\_

PAST PSYCHOLOGICAL/PSYCHIATRIC HISTORY-OUTPATIENT OR IN HOSPITAL:

Dates	Hospital/Agency	Problem	Helpful or Not
_____	_____	_____	_____

FOOD ISSUES: \_\_\_\_\_ bingeing \_\_\_\_\_ vomiting \_\_\_\_\_ compulsive/overeating \_\_\_\_\_ overuse of laxatives  
\_\_\_\_\_ diuretic abuse \_\_\_\_\_ not eating \_\_\_\_\_ Other: Describe: \_\_\_\_\_

ADDICTIVE ISSUES: \_\_\_\_\_ gambling \_\_\_\_\_ exercise \_\_\_\_\_ pornography \_\_\_\_\_ internet \_\_\_\_\_ sex \_\_\_\_\_ hair pulling  
\_\_\_\_\_ shoplifting/stealing \_\_\_\_\_ compulsive (perfection): describe: \_\_\_\_\_

CIGARETTE/SMOKING HISTORY: Do you smoke/chew now? \_\_\_\_\_ Yes \_\_\_\_\_ No If "YES": How much daily? \_\_\_\_\_  
How many years? \_\_\_\_\_ Did you smoke/chew in past? \_\_\_\_\_ Yes \_\_\_\_\_ No If "YES": How many years? \_\_\_\_\_

ALCOHOL HISTORY: Do you use alcohol now? \_\_\_\_\_ Yes \_\_\_\_\_ No If "YES": How much weekly? \_\_\_\_\_  
How many years? \_\_\_\_\_ Did you use alcohol in past but not now? \_\_\_\_\_ Yes \_\_\_\_\_ No If "YES": Years? \_\_\_\_\_  
Is alcohol a problem in your life? \_\_\_\_\_ No \_\_\_\_\_ Yes: describe: \_\_\_\_\_  
DUI: \_\_\_\_\_ No \_\_\_\_\_ Yes If "Yes": How many? \_\_\_\_\_ Date of last one: \_\_\_\_\_

DRUG USE: EXCLUDING PRESCRIBED MEDICATION:

Do you use drugs now? \_\_\_\_\_ Yes \_\_\_\_\_ No If "YES": Describe what: \_\_\_\_\_  
How much weekly? \_\_\_\_\_ How many years? \_\_\_\_\_  
Did you use drugs in the past but not now? \_\_\_\_\_ No \_\_\_\_\_ Yes If "YES": Describe what: \_\_\_\_\_  
Amount used in week: \_\_\_\_\_ How many years used? \_\_\_\_\_  
Are drugs a problem in your life? \_\_\_\_\_ No \_\_\_\_\_ Yes: describe: \_\_\_\_\_

SOCIAL HISTORY: Describe yourself: \_\_\_\_\_  
\_\_\_\_\_

What do you like about yourself: \_\_\_\_\_  
\_\_\_\_\_

Where does your strength come from? Example: Spirituality, Inner Strength, Own Values, Family, etc.  
\_\_\_\_\_  
\_\_\_\_\_

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NAME: \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_

How do you see the world/others? \_\_\_\_\_

What would you like to change in your life? \_\_\_\_\_

Circle one

I have close friends/close family members: none a few some many a lot  
For enjoyment, I \_\_\_\_\_

Describe your social, recreational, exercise activities: \_\_\_\_\_

MEDICAL HISTORY:

PHYSICIAN NAME: \_\_\_\_\_ Group: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last time you met with you doctor: \_\_\_\_\_ : Results: \_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_ : Results: \_\_\_\_\_

ALLERGIES: Are you allergic to any foods, drinks, spices, etc: \_\_\_ No \_\_\_ Yes: Describe: \_\_\_\_\_

ALLERGIES: Are you allergic to any drugs/medicine: \_\_\_ No \_\_\_ Yes: Describe: \_\_\_\_\_

ALLERGIES: Are you allergic to anything: \_\_\_ No \_\_\_ Yes: Describe: \_\_\_\_\_

CURRENT

Do you currently have any of the following:

- TB  Hepatitis  Venereal Disease  Bleeding gums  Difficulty Hearing
- Fever  Infection  Vision Difficulty  Severe Headaches  Dizziness
- Coughing  Colds  Night Sweating  Jerking Legs  Stomach pain
- Vomiting  Nose bleeds  Urinating Problems  Convulsions  Blood in Urine
- Kidney Stones  Blueness of lips, nails  Stiffness/generalized pain
- Heart/Lung Issues  OTHER: Describe: \_\_\_\_\_
- I DON'T HAVE ANY OF THE ABOVE.

PAST (check only if YES):

- Measles  Asthma  Ulcers  Gonorrhea  Malaria
- Chicken Pox  Broken Bones  Heart Problems  Syphilis  TB
- Thyroid Fever  Hives  Stroke  Brain Trauma  Mono
- Mumps  Urinary Problems  Diabetes  Thyroid Problems  HIV/AIDS
- Polio  Pneumonia  Cancer  Anemia
- Emotional Problems  OTHER: Describe: \_\_\_\_\_

WOMEN ONLY

Do you have any menstrual period problems? \_\_\_ No \_\_\_ Yes: Describe: \_\_\_\_\_

Are you pregnant? \_\_\_ No \_\_\_ Yes: Due Date: \_\_\_\_\_ Are you receiving prenatal care? \_\_\_ No \_\_\_ Yes

Please check if you had: \_\_\_ pregnancies \_\_\_ Miscarriages \_\_\_ Stillbirths \_\_\_ Abortions LAST GYN: \_\_\_\_\_

FAMILY MEDICAL HISTORY

Father: Age: \_\_\_\_\_ Current Health: \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Current Health: \_\_\_\_\_

Brother/sisters: Health Problems: \_\_\_\_\_

Spouse/Significant Other: Health Problems: \_\_\_\_\_

Do any of your blood relatives, grandparents, aunts, uncles, etc have a history of?

- Cancer  Heart Problems  Cancer  Diabetes  High Blood Pressure  Seizures
- High Cholesterol  Sickle Cell  TB  OTHER: \_\_\_\_\_

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**OTHER MENTAL HEALTH PROVIDERS:**

Are you currently being treated or seen by any other mental health provider?

Counselor: \_\_\_ No \_\_\_ Yes: If YES: Name: \_\_\_\_\_ PH #: \_\_\_\_\_  
Psychiatrist: \_\_\_ No \_\_\_ Yes: If YES: Name: \_\_\_\_\_ PH #: \_\_\_\_\_

**MEDICATIONS: ONLY FROM YOUR PSYCHIATRIST:** Please list all medications from your psychiatrist that you are currently taking: OR BRING IN A LIST THOSE MEDICATIONS WITH THE FOLLOWING INFORMATION.

NAME OF MEDICATIONS	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE LIST YOUR PSYCHIATRIST'S MEDICATIONS ABOVE; YOU DO NOT NEED TO REPEAT THEM BELOW.**

**MEDICATIONS: FROM YOUR FAMILY DOCTOR/SPECIALISTS:** Please list all medications that you are currently taking: OR YOU CAN BRING IN A LIST OF ALL MEDICATIONS WITH THE FOLLOWING INFORMATION.

NAME	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any over the counter medications/dietary supplements/herbal/etc:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE NOTIFY THERAPIST IF YOUR DOCTOR CHANGES MEDICATION**

\_\_\_\_\_  
Patient's Signature Date

**CUMBERLAND VALLEY COUNSELING ASSOCIATES  
CLIENT RIGHTS NOTIFICATION**

As a recipient of services at our facility, we would like to inform you of your rights as a client and the process for reporting a violation of your rights.

**Your rights as a client include the right to:**

1. be treated with respect and dignity
2. make complaints and have your complaints heard
3. make suggestions about the services that are provided
4. have your civil rights protected by federal and state laws
5. receive attention to and care for cultural/spiritual/gender needs and receive this care by a therapist with specific training or experiences to meet these needs. If these services are not available at CVCA, we will help you in the referral process
6. receive appropriate treatment and take part in formulating your treatment plan
7. refuse any therapies or services that may be recommended by your therapist
8. be apprised of treatment benefits and risks
9. request restricted use of your protected health records
10. obtain a copy and/or inspect your protected health information; however, CVCA may deny access to certain records, in which case CVCA will discuss this decision with you
11. request an amendment in your records; however, this request may be denied. If denied, your request will be kept in the records.
12. discuss your treatment with your doctor or attorney
13. receive an accounting of disclosures of your protected health information that you have not authorized

**You have the right to receive information about:**

1. cost of services that CVCA provides
2. what behaviors or violations could lead to termination of services at CVCA
3. confidentiality and the extent and limits of your protected health information and how it will be used
4. any policy changes that affect your treatment or services.

**Our ethical obligations to you include:**

1. CVCA is dedicated to serving the best interest of each client
2. CVCA will not discriminate among clients or professionals based on age, race, creed, gender, orientation, disabilities, handicaps, preferences or other personal concerns
3. CVCA maintains an objective and professional relationship with each client
4. CVCA respects the rights and views of other professionals
5. CVCA will end services or refer clients to other programs when appropriate
6. CVCA therapists engage in ongoing activities, including continuing education and clinical and peer supervision, in order to increase professional growth and effectiveness
7. CVCA holds respect for various institutional and managerial policies, but will review and amend such policies in the best interests of the practice and CVCA clientele

**Your responsibilities as a client include:**

1. to fulfill your financial obligations to CVCA as outlined in the ***Payment Contract for Services***
2. to follow the policies of CVCA
3. to treat staff and fellow clients in a respectful, cordial manner so that their rights are not violated
4. to provide accurate information about yourself

**IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED, PLEASE CONTACT  
 THE PRESIDENT OF THE BOARD OF CVCA.**

**Office staff can provide you with the president's contact information.**

**CUMBERLAND VALLEY COUNSELING ASSOCIATES****PRIVACY OF INFORMATION POLICIES**

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.**

**OUR LEGAL DUTIES:**

State and Federal laws require that CVCA keeps your medical records private. CVCA has the right to change policies only if the changes comply with all pertinent laws. Information given to the therapist during treatment – intake, evaluation, counseling sessions – are covered by these laws as private information. CVCA respects your privacy and abides by ethical and legal requirements regarding confidentiality of records.

**USE OF INFORMATION:**

Information that you provide to CVCA is used for diagnosis, treatment planning, treatment and continuity of care. With your written permission, pertinent information will be disclosed to your insurance company, your family physician and to any other person that you give written permission permitting the release of information.

CVCA will not release information about you **without** your written permission. However, certain laws require CVCA to release information with or without your permission. The following lists many of these situations but is not intended as an exclusive list as laws may change.

**1. Duty to Warn and Protect:**

When a client discloses intention or plan to harm another person(s), CVCA is required to warn the intended victim and report this information to legal authorities. When a client discloses or implies intent and plan for suicide and has the means to carry out the plan, CVCA is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**2. Public Safety:**

A client's record, or portions, may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military and when complying with worker's compensation laws.

**3. Abuse:**

If a client states or suggests that he/she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, CVCA is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence or a crime victim, and their safety appears to be at risk, CVCA may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**4. Prenatal Exposure to Controlled Substances:**

CVCA is required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**5. In the Event of a Client's Death:**

If a client dies, the spouse or parents of the deceased person have a right to access their child's or spouse's record.

**6. Professional Misconduct:**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is held, related records may be requested in order to substantiate disciplinary concerns.

**7. Judicial or Administrative Proceedings:**

Health care professionals are required to release records of clients when a court order has been placed.

**8. Minors/Guardianship:**

Parents/legal guardians of non-emancipated minor clients have the right to access the minor's records.

## CUMBERLAND VALLEY COUNSELING ASSOCIATES

### PRIVACY OF INFORMATION POLICIES

#### 9. Other Provisions:

- The person responsible for payment of services is responsible for making payments or working out a payment plan; if such does not happen, CVCA has the right to utilize a collection agency. The information disclosed is the amount of payment. If the debt remains unpaid and no payment plan has been agreed to, the amount of the debt, the time period and the name of the agency, may be disclosed to credit agencies.
- Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information may include: type of service, dates/times, diagnosis, treatment plan, description of impairment, progress of therapy and summaries.
- Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases, the name of the client, or any identifying information, is not disclosed. Clinical information is discussed. Some progress notes and reports may be dictated/typed within the clinic or by outside sources specializing in and held accountable for such procedures.
- CVCA contracts with a 24/7 answering service; clients calling CVCA and using the answering service may provide their name, phone number and other personal information. The answering service is held to confidentiality requirements as is CVCA: the answering service discloses information only to CVCA personnel.
- Clients are asked by CVCA personnel regarding restrictions about leaving phone messages for the client and/or mailing information to the client.

#### Your Rights:

- You have the right to request to review or receive your medical file. The procedure is to provide a written request with original signature to CVCA. If the request is denied, you will receive a written explanation of the denial. Records of non-emancipated minors must be requested by custodial parent(s) or legal guardian. The charge is \$1.00 per page plus postage.
- You have the right to cancel a release of information by providing CVCA a written notice. If you desire to have information sent to an address different than your address on file, you must indicate so in writing.
- You have the right to restrict which information may be disclosed to others; however, if CVCA does not agree, it may not be bound by your wish, i.e. court subpoena.
- You have the right to disagree with information in your file and may request to change it. If CVCA does not agree with the change, it will amend your file; however, you have the right to have your statement of disagreement placed in your medical file.
- You have the right to know what information in your file has been released to whom; request this in writing.

This material will be reviewed with you or provided to you at your initial appointment; it is also posted on the Client Information Board in the waiting room. You may request a copy of this information.

#### Complaints:

**If you have any complaints or questions regarding these procedures, please contact the CVCA Director or the Risk Manager. You may also submit a complaint to the U.S. Department of Health and Human Services and/or the State Boards.**