



CATHOLIC CHARITIES
Of Eastern Virginia

Client Intake Form

Date: _____

Client Name: _____

Date of Birth: _____

Reason for visit: _____

How were you referred to us? _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Email Address: _____

Demographics *(Please complete for statistical purposes only)*

Total Number of People in Household: _____

Total Annual Household Income: (Gross)	\$0-\$10,000 <input type="checkbox"/>	\$10,000-\$20,000 <input type="checkbox"/>	\$20,000-\$30,000 <input type="checkbox"/>
	\$30,000-\$40,000 <input type="checkbox"/>	\$40,000-\$50,000 <input type="checkbox"/>	\$50,000-\$60,000 <input type="checkbox"/>
	\$60,000-\$70,000 <input type="checkbox"/>	\$70,000-\$80,000 <input type="checkbox"/>	

Marital Status: Single Married

Gender: Male Female

Race: African-American Asian Caucasian Hispanic
 Native American Other

Military Status: Active Duty Retired Veteran Non-applicable

Employment Status: Employed Unemployed Retired Receiving Disability

Emergency Contact Information

Primary Emergency Contact Name: _____

Phone Number: _____ Relationship to Client: _____

Catholic Charities of Eastern Virginia, Inc.
Mental Health Counseling – Client Intake Form

Client Name: _____

Current Medications & Reason for Taking:	Dosage	Prescribing M.D.	Date Began
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please circle your current symptoms: Frequent Headaches Nervousness Crying Easily Fearful
Problems Concentrating Sleep Difficulty Change in Appetite Guilt Restlessness Racing Thoughts
Frequent Stomach Problems Hearing Voices Loss of Sexual Interest Memory Problems Anger/Temper
Worrying Pounding/Racing Heart Dizzy Spells Shy Vision Problems Hyperactive Irritability
Suicidal (if yes, explain): _____

History of health problems, chronic illness, medical issues:

Mental Health history, including family history (include substance use/abuse, suicide, anxiety, depression, etc):
Self:

History of mental health counseling services, including hospitalizations:

History of legal problems (include incarcerations, DUI's, child custody, etc.):

Please give a brief description of your reason for seeking counseling services:

What goals do you hope to achieve with counseling?

Consent for Treatment

Mental Health Counseling



Client Name: _____

Address/City/State/Zip: _____

Date of Birth: _____

Catholic Charities of Eastern Virginia, Inc., (CCEVA) is a non-profit social service agency. This document is designed to inform you about the clinical counseling services of CCEVA.

Confidentiality & Privacy Practices / Purpose of Use of Confidential Information: Your counselor will keep confidential the information you disclose with the following exceptions: a) you request in writing that your counselor disclose specific information to a third party (authorization which may be withdrawn at any time); b) your counselor and/or another professional believes that you are a danger to yourself or others; c) your counselor or the agency is court-ordered to disclose information; d) there is suspicion of child or elder abuse/neglect;

Purpose: Counseling is designed to provide support and intervention for people who identify personal emotional challenges and mental health concerns. Counselors respect the dignity of clients and promote the highest possible level of functioning.

Participation & Termination: Counseling services are voluntary and clients may terminate their services at any time. It is suggested that you discuss termination with your counselor prior to ending treatment. Termination may be appropriate when treatment goals have been met, when a client no longer wants or chooses service, when the agency cannot provide services needed, when a client or therapist relocates out of the servicing area, or a therapist becomes incapacitated. Other conditions may warrant termination of counseling services and may be dependent upon the safety and well being of agency clients and staff. Counselors make referrals within the agency and/or within the community when appropriate during the termination process.

Goals: Together you and your counselor will establish treatment goals based on what you have identified as a problem or concern. Treatment goals assist clients and counselors in determining the length and frequency of needed services.

Techniques: You may read about your counselor's use of counseling theory and techniques in his/her Professional Disclosure Statement. Videotaping, audio-taping, photography and/or media releases will require a client's written consent.

The agency does not permit the use of any unorthodox service modalities, behavior modification interventions or activities, or restraints of any kind.

Procedures: Counselors facilitate 45-50 minute counseling sessions in a safe environment. Please arrive promptly for your appointment, otherwise you may be charged for a late cancellation. Contact with your counselor should be limited to session time and emergency phone calls only. Please do not invite your counselor to personal gatherings or offer gifts. Clients are best served if the counselor-client relationship remains strictly professional and the sessions focus on client concerns.

Limitations, Risks & Benefits: Change can be both beneficial and uncertain. Counseling can provide the opportunity for personal growth, for improved emotional satisfaction, for improved relationships, and improved understanding or handling of life circumstances. Sometimes counseling brings out emotions and feelings that may be uncomfortable. If this occurs, be sure to talk to your counselor about your feelings to help address the issues surrounding this discomfort. Counseling cannot always guarantee the results you may be expecting, and, the outcome of counseling is dependent upon many factors.

Counselor Qualifications & Credentials: Counselors are employees of CCEVA and hold a Master's Degree in Counseling or Social Work and are licensed or license eligible to practice counseling in the Commonwealth of Virginia. In addition, a student intern may be available to work with you, in which case you will be given information regarding intern services and his/her supervisor.

Interruptions of Counseling Services: If for any reason your counselor becomes unavailable to serve you, you may have several options for continuation of care. Your counselor has provided this information in his/her Professional Disclosure Statement. The Clinical Director is available to assist you in the event that your counselor abruptly leaves the agency.

Record Keeping: Clinical counseling records may be available to you upon your written request. Closed clinical counseling records are maintained for 6 years and are then destroyed. If the client is a minor, records are destroyed 6 years after they turn 18 years of age. Financial and billing information are included in the case record.

Counseling Minors: Catholic Charities abides by the treatment laws for minors established in the Commonwealth of Virginia. Counselors encourage minors to include parents/legal guardians in the decision to seek counseling services when appropriate.

Grievance Procedure: While we strive to provide quality services, you may decide to file a formal complaint. The following procedures explain the process for filing a grievance with CCEVA. Please know that resolution may occur at any point in the process. 1). Discuss your concern with your therapist. If unresolved, proceed to step two: 2). Describe your concern in writing and present it to the Clinical Director with your therapist present. If unresolved, proceed to step three: 3). Describe your concern in writing and present it to the CEO with the Clinical Director present.

Fees & Billing Arrangements: The fee process is described in the agency's Therapy Fee Agreement. Fees are based on a sliding fee scale with proof of income for uninsured clients.

Our Notice of Privacy Practices accompanies this document. Please discuss any questions or concerns you may have with your counselor. By signing this form, you acknowledge receipt of our Privacy Practices, as well as your Rights and Responsibilities as a Client of CCEVA.

I have read and I understand the Information & Consent Statements. My signature indicates my understanding and agreement to the counseling services provided by Catholic Charities of Eastern Virginia, Inc.

Client/Legal Guardian Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

CATHOLIC CHARITIES OF EASTERN VIRGINIA, INC.
Mental Health Counseling
Therapy Fee Agreement

Catholic Charities of Eastern Virginia, Inc. is a nonprofit family services agency supported by contributions from the United Way, the Catholic Diocese of Richmond, the local parishes in Eastern Virginia, and fees for services.

Client Name _____
(First) (M.I.) (Last)

Payment Selection

_____ Licensed Counselor \$50.00
_____ Resident Counselor \$35.00
_____ Intern Counselor \$25.00
_____ Parish Assistance \$ _____
_____ Mother Teresa \$ _____ (with proof of income for those who qualify)

Please read the following information carefully. Initial each item:

1. I understand that client payment is expected prior to services rendered. _____ (initials)
2. I understand that Catholic Charities of Eastern Virginia, Inc. requires a 24-hour notice of a cancellation of any appointment. Failure to cancel within 24 hours of a scheduled appointment may result in a "No Show" charge. **The "No Show" charge will be equal to what you currently pay for counseling services. For example: fee for services \$35.00 your "No Show" fee would be \$35.00.**
(Charge incurred at the counselor's discretion) _____ (initials)
3. I understand that Catholic Charities of Eastern Virginia, Inc. may refuse to see me if my account is in arrears. _____ (initials)
4. I understand that my fee agreement may be reevaluated as needed and updated according to financial changes. _____ (initials)
5. I understand that if a Catholic Charities of Eastern Virginia, Inc. counselor is subpoenaed to court regarding services rendered to my family or myself, I will pay in advance a flat fee of \$150.00 plus \$80 for the first hour counselor is expected at court for a total of \$230.00 due prior to the court date. If a counselor is at court for more than one hour, the client agrees to pay \$80.00 for each additional hour the counselor is at court. _____ (initials)
6. I understand that any letters requested and written on my behalf or paperwork (includes SSI and SSDI) to be completed by a counselor of Catholic Charities of Eastern Virginia, Inc., will result in a standard charge that is due upon my completion of the written authorization for the release of the documents. A two week notice for preparation of the documents is necessary. _____ (initials)
7. I understand that if I request a copy of all or part of my clinical record there will be a per page fee payment and completion of the necessary release form prior to release of my record. All requests for release of records are reviewed by the Clinical Director prior to release. _____ (initials)

Your signature below indicates understanding of the financial obligations for Mental Health Counseling Services with Catholic Charities of Eastern Virginia, Inc.

Signature of Client or Responsible Party

Date

Signature of Agency Representative

Date

Catholic Charities of Eastern Virginia, Inc.
Mental Health Counseling

Cancellation and No Show Policy

As noted on the Consent for Treatment form, clients also have certain responsibilities while under Catholic Charities' care.

It is Catholic Charities' responsibility to treat our clients with respect and dignity among many others as noted.

Our agency, as many others, has been experiencing an increased number of cancellations and "no shows." This is to be expected and at times unavoidable. But we do ask for your cooperation in the following manner:

1)...If an unexpected situation occurs and you need to cancel and reschedule, we ask that you do so, if at all possible, 24 hours before the appointment. This is to give the agency the ability to schedule another client in that hour.

2)...If you cancel the day of the appointment and it is a true emergency, no charge will be assessed for the missed appointment.

3)... If you do not cancel or reschedule, it is a "no show". Later calls to reschedule will be up to the therapist to determine if there was a valid and unavoidable excuse for doing so.

4)...If you are receiving help through our sponsorship program and have either a reduced fee or no fee and have a 2nd unexcused "no show", the therapist can decide with the Clinical Director whether that person loses their grant and will have to pay the full fee from that point on.

5)...If you drop out of treatment due to loss of the grant or refuse to pay the "no show" fee, your case will be closed. The client is free to return after 90 days unless there are special circumstances. All uncollected fees must be paid in full prior to your case being reopened.

Client Signature: _____ Date: _____

CCEVA Representative: _____ Date: _____

Catholic Charities of Eastern Virginia, Inc.

Mental Health Counseling

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name _____ Date of Birth _____

I hereby request that Catholic Charities of Eastern Virginia, Inc. only communicates with me using the following method(s): *(Examples: only at work, only by mail, only during afternoon hours, etc. Please specify the phone number, address, etc.)*

I understand it is the policy of Catholic Charities of Eastern Virginia, Inc. to accommodate all reasonable requests.

Signature

Date

(Form to remain in record.)

Catholic Charities of Eastern Virginia

Mental Health Counseling

On-Call Policy

As noted on your counselor’s Disclosure Form, Catholic Charities provides on-call services for **identified patients (IPs)** experiencing a mental health crisis after normal business hours. The on-call worker does not provide counseling via telephone, but rather offers a brief service to assist with life threatening mental health concerns. If such a situation arises, please call the on-call counselor or immediately dial 911.

We ask that you do not share the on-call number with individuals who are not currently receiving direct counseling services from a counselor employed by Catholic Charities of Eastern Virginia.

On-Call Number: 757-274-4956

If you have any questions, please direct them toward your counselor during your intake session.

I understand the policy of Catholic Charities of Eastern Virginia, Inc. involved on-call services and hereby acknowledge I will not provide the number to individuals not currently receiving counseling services from CCEVA.

Signature

Date

CCEVA Representative

Date

Catholic Charities of Eastern Virginia

Mental Health Counseling

Record Release/ Letter Request/Completing Paperwork

Catholic Charities of Eastern Virginia (CCEVA) maintains client records for all clients receiving mental health counseling. **For all documentation requests and for request of records**, we ask that you provide the counselor with **two weeks** notice prior to the date information is needed.

If client is requesting a letter, the fee for this service will be \$35.00. Client will need to sign a release giving written permission for CCEVA counselor to communicate via letter with a third party on their behalf.

If client is requesting documentation be filled out for Social Security Disability Insurance, the fee for this service will be \$35.00. Client will need to sign a release giving written permission for CCEVA counselor to communicate with Social Security Disability Insurance on their behalf.

If client is requesting a copy of their record, client will need to fill out a Request for a Copy of Record Form and pay the standard fee for records which is .50 per page for first 50 pages and .25 for each page thereafter.

If client is requesting a copy of their record to be sent to a third party, they will need to fill out a Request for a Copy of Record form, fill out an authorization to release information to a third party giving CCEVA counselor written permission to do so and inform counselor if they will pay for the records or the third party will pay for the records.

I understand the policy of Catholic Charities of Eastern Virginia, Inc. regarding the request and release of records.

Signature

Date



Statement Regarding Handling Dangerous/Inappropriate Behaviors

CCEVA does not utilize any practice involving point systems, level systems, time outs, or manual restraints. We do not provide any direct client service which necessitates the need for such practices. We do not operate any residential services, nor do we operate a therapeutic foster care program. Our clients are only seen on an outpatient basis, or as participants in classes. In the event that any client exhibits out of control behavior, our approach is to attempt to verbally calm the client, in a non-threatening manner, and to promote the safety and dignity of both client and staff members. When a client demonstrates an inability or unwillingness to control his/her behavior, we call the local police. It is our policy that no staff member is to physically engage any client in an attempt to control that client's behavior, nor are they allowed to use any restrictive behavior.

In the event an employee, student intern or volunteer encounters a client who presents inappropriate or dangerous behavior, the following guidelines are to be used:

- No clients shall be subjected to physical or verbal abuse.
- Inappropriate behavior should be responded to by ignoring the behavior in such a manner as not to endanger the safety of the client or worker. Appropriate behavior should be reinforced with positive responses.
- In the event the client is threatening to harm others or themselves, the police will be notified, and notification to the person being threatened if that person is not aware of the threat. Workers are not expected to place themselves in jeopardy. Workers should use prudence in withdrawing from the situation.

By signing this statement, I acknowledge that I have read the above statement and understand the Dangerous and Inappropriate Behavior policy of Catholic Charities of Eastern Virginia.

Client Signature

Date

Print Client Name

Catholic Charities of Eastern Virginia, Inc.

Clients Rights and Responsibilities

You have the right:

- o To be treated with dignity and respect.
- o To participate in the planning of your services, and be advised of any changes in the planning of services provided to you.
- o To receive services in a manner that is non-coercive and protects your right to self-determination.
- o To be served by individuals who are competent and properly trained.
- o To be free from mental and physical abuse and property exploitation.
- o To expect non-discrimination in the services provided you.
- o To be assured of privacy and the confidential treatment of your records (except in situations where you are harmful to yourself or others, or when mandated by law or for public health activities).
- o To have your family or guardian exercise your rights for you if you have been judged incapable of doing so yourself.
- o To be provided needed care after your third party benefits have terminated if in a critical situation.
- o To request further information concerning anything you do not understand, and have arrangements made to assist with communication if you have special needs, are hearing impaired, or need a language translator.
- o To refuse services, (unless mandated by law or court order) after being advised of the possible consequences of such refusal.
- o To lodge a complaint/grievance, have it investigated, and have its resolution documented without interference or retaliation (discuss procedural steps with the staff member serving you).
- o To request a copy of these rights.

You have the responsibility:

- o To notify us if you need to change a pre-scheduled appointment.
- o To behave in a reasonable and responsible way.
- o To participate in the planning of services.
- o To follow the plan of service and carry out mutually agreed upon responsibilities.
- o To give accurate and complete health information concerning your current and past situations, illnesses, hospitalizations, medications and other pertinent information.
- o To report any changes in your contact information, health condition, medications, treatments, doctor's instructions and other information that would affect progress toward goals.
- o To pay any fees for services rendered.

Client signature and Date

Catholic Charities of Eastern Virginia, Inc.

Clients Rights and Responsibilities – Client Copy

You have the right:

- To be treated with dignity and respect.
- To participate in the planning of your services, and be advised of any changes in the planning of services provided to you.
- To receive services in a manner that is non-coercive and protects your right to self-determination.
- To be served by individuals who are competent and properly trained.
- To be free from mental and physical abuse and property exploitation.
- To expect non-discrimination in the services provided you.
- To be assured of privacy and the confidential treatment of your records (except in situations where you are harmful to yourself or others, or when mandated by law or for public health activities).
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