NEW CLIENT INFORMATION

(Please fill with black or blue pen only)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Date:		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Ethnicity:	Birth date: / /	Age:	Gender:
Street address:		Sexual Orientation:	Best Phone Number to reach you:		
Yearly Income: (Estimate:) $ _____	City:	State:	ZIP Code:		

Referred to by (please check one box): ❑ Counselor ❑ Friend ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Other

INSURANCE INFORMATION

(Please provide Insurance Card and ID to Intake Provider)

Person responsible for minor:	Birth date: / /	Address (if different):	Home phone no.: ( )

Has this person been seen here before? ❑ Yes ❑ No Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I certify that the information I have reported with regards to my insurance coverage is correct.

X _____ X _____

Client Signature Parent/Legal Guardian Signature

UCF
UNITED CITIZENS FOUNDATION

Please write a brief statement of why you are seeking treatment:

Signature: _____ Date: _____

Print Name: _____

Patient Name: _____ Parent or Guardian Name: _____

Informed Consent, Patient Rights, Medicaid Ch. 400, Ancillary Services
Notice of Privacy Practices, HIPAA, 42CFR Part 2~ Receipt &Acknowledgement of Notices
Treatment Protocols, Partnerships/Group Rules & Contract for Therapy

Patient Initial ____ Parent/Legal Guardian Initial ____ Group (if requested) and Individual Rules, Expectations

Punctuality and Attendance: All members must be on time and attend all sessions as indicated within contractual agreement. Counseling services are individualized to meet the needs of the client and/or family.
Confidentiality: What you hear in-group, stays in-group. Everyone is to be afforded their anonymity. Do not discuss any other group members' words or actions with anyone outside of the group.
Participation: You can openly discuss any topic, however, others can give you feedback, including how you appear or sound to them as long as it is done in an appropriate manner.
Right of Refusal: You can refuse to do things that trigger uncomfortable feelings, but others can give you feedback.
No Violence: Verbal, physical, and/or any threats of violence, are grounds for dismissal.
No Dating, Romantic Involvement, or Sexual Involvement: This can hurt you and your treatment process. Refrain from any of these activities with group members.
Communication Before Termination: If you decide to leave the group, talk to the group facilitator before leaving.
Check Out Feelings or Meanings: When you believe another person is thinking or feeling a certain way, ask for confirmation. Always ask clarifying questions when others are presenting subject matter and you are not able to fully understand.
Responsibility: It is the responsibility of the group members to complete all exercises as assigned by group facilitator. It is also the responsibility of the group members to actively listen to others about what they are saying as it provides an opportunity to learn effective communication skills and helps when responding to others.
Choice of Therapist: Client has the right to choose his/her own treating clinician.

Patient Initial ____ Parent/Legal Guardian Initial ____ Cancellations/Fees

Please notify UCF within 24 hours if you wish to cancel or reschedule your appointment. Appointments are at a first come first serve basis but may also be rescheduled due to an emergency/crisis. We do prioritize emergency/crisis situations so under certain circumstances, you may be rescheduled. If this applies, please notify the intake personnel at your location as early as possible to accommodate. All appointment times have a 15-minute grace period before we consider you a "no show." Four "no shows" will result in a discharge from the program.

Although there are no fees associated with our school-based programs, we do collect insurance information from each client for possible session reimbursement. Reimbursement funds collected from insurance companies help to defray program costs and help to ensure the continuation of mental health services to all students in need.

Patient Initial ____ Parent/Legal Guardian Initial ____ Disclosure by third parties

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand if the authorized recipient of the information is not a health care provider or health care plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I further understand I need not sign this Authorization to ensure health care treatment, payment, enrollment in a health plan, or eligibility for benefits. I acknowledge I have been informed of my right to be given a copy of this Authorization after signing it. I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner described above. I understand if communicating via cell phone the conversation may not be secure and therefore not confidential.

Patient Initial ____ Parent/Legal Guardian Initial ____ Telemedicine, Alternative Forms of Communication

I understand communication (e.g. emails and chats) with UCF and any of their contractors via the site are encrypted and emails sent from or to personal email accounts are not secure. I also understand UCF, and any of their contractors may not check personal email regularly. I further acknowledge and agree all communication of a clinical nature should be sent via phone. A reasonable attempt will be made to read and respond to the emails received via the site within 24 to 48 hours. I further acknowledge and understand UCF and any of their contractors will not respond to personal and clinical concerns via regular email or texting. Regular email should not be used in the event of a crisis or an emergency. I understand UCF will not accept my invitations via social media websites, networking websites, instant messenger, or respond to blogs written by me or accept my comments on their blog(s).

I understand if I choose to do therapy that is conducted online that it is technical in nature and problems may occur with internet connectivity. Internet availability may be limited or disrupted by things such as server maintenance, upgrades, or other problems (such as software or hardware malfunction). Any problems with internet availability or connectivity are outside the control of UCF, their contractors, staff, affiliates/third party partners, Office Ally, and all other webpage affiliations incorporated with providing my treatment process and makes no guarantee such services will be available. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via telephone, a new appointment will be re-scheduled.

I understand if I need to speak with UCF and any of their contractors between sessions to alert them of an emergency, I should call the office line. My call will be returned as soon as possible. I acknowledge messages are generally checked daily, but are not checked at night, on weekends, or on holidays. If an emergency situation arises that requires immediate attention, I should call the emergency National Hopeline Network at 1-800-Suicide/1-800-784-2433, National Suicide Prevention Lifeline at 1-800-Talk /1-800-273-8255, or dial 911. Hearing and Speech Impaired should call 1-800-799-4TTY/1-800-799-4889. I understand in the event of a life-threatening crisis I should contact a crisis hotline, call 911, or go to a hospital emergency room.

Additionally, although UCF has taken substantial steps to ensure the confidentiality and privacy of therapy if and when provided online, UCF cannot guarantee the security of any internet transmissions or communications. **I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.**

I agree to defend, release, and indemnify UCF, their contractors, staff, affiliates/third party partners, Office Ally, and all other webpage affiliations, from and against all damages, costs, suits, claims, and other actions originating from any services provided to me by their contractors, staff, affiliates/third party partners, Office Ally, and all other webpage affiliations, incorporated with providing my treatment process.

Patient Initial ____ Parent/Legal Guardian Initial ____

Notice of Privacy Practices -HIPPA, 42CFR Part 2, Medicaid Ch. 400, Treatment Protocols, Partnerships & Consent to Treatment

I hereby acknowledge I received and have been given the opportunity to read a copy of UCF's notice of privacy practices, HIPPA, and 42CFR Part 2. I understand if I have any questions regarding the notice or my privacy rights, I can contact the agency at the address listed. I do hereby signify my understanding of the full nature, benefits, risks, and purpose of the treatment plan set forth in my case by UCF. I further understand I reserve the right to refuse treatment under that plan at any time and the UCF reserves the right to discharge me from treatment if at all I am determined unsuitable for treatment within the company's structure. At that time, UCF may make recommendations concerning my future treatment to appropriate individuals and/or entities. I also hereby signify my understanding that treatment methods within UCF's modality may, at times and in specific instances, tend to limit certain rights to which I might be otherwise entitled. I hereby have been informed of the above treatment protocols and understand the requirements of the counseling program.

I understand my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160, 162 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows at time of discharge. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form. I fully understand my participation in this treatment program is voluntary, and I may withdraw from treatment at any time. I fully understand if I choose to withdraw from treatment I will not be refunded any of the fees paid in advance. I hereby acknowledge I have received and have been given the opportunity to read a copy of UCF Notice of Privacy Practices. I understand if I have any questions regarding the Notice or my privacy rights, I can contact UCF at the address listed.

I hereby acknowledge I have been informed of my rights under the provisions of the Division of Healthcare and Financing Policy Medicaid Chapter 400 and understand my rights as it relates to selecting a provider of choice. I authorize the release of any information (including treatment summaries and diagnosis) necessary to process insurance or employee assistance claims, or to request additional sessions. I authorize payment of benefits to be made to UCF for services provided.

_____	_____	_____
Signature Client	Printed Name	Date
_____	_____	_____
Signature Parent, Guardian or Legal Rep.	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date

For Clark County School District (CCSD) School Based Sites

I understand UCF's Clinical Treatment Staff may recommend and refer me to a more appropriate level of care if my needs are beyond the department's current scope of services. I fully understand I have responsibilities while in this treatment program. These are outlined in the treatment contract which I have read, understood, and agreed to. At their discretion, the therapist may discuss my treatment progress in therapy with relevant professionals and those listed on the attached releases of information. I, understand UCF is a grant funded nonprofit that has partnerships to assist in our families/individual treatment goals. I authorize *UCF's Behavioral Health Department, the participating Student Interns/Professors of UNLV and UCF internship, the Clark County School District staff that is assigned to our family, family assigned staff of Nevada PEP, medical providers assigned to our family of First Persons, medical*

providers assigned to our family of Nevada Health Centers, and staff of Nevada WIN to communicate with and disclose to one another my name and my children's name/other personal identifying information; my status/my children's status as a client; initial evaluation; date of admission; summary of treatment plan, progress, and compliance; attendance; changes in address, household composition or personal relationships; discharge plan; date of discharge, discharge status. I understand my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160, 162 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows at time of discharge. I will not be denied services if I refuse to consent to the above disclosure and I have been provided a copy of this form.

_____	_____	_____
Signature Client	Printed Name	Date
_____	_____	_____
Signature Parent, Guardian or Legal Rep.	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date

GRIEVANCE

POLICY ACKNOWLEGEMENT

United Citizens Foundation
Operations Manager
4485 South Buffalo Drive
Las Vegas, NV 89147
Ph: 702-722-2440
Fax: 702-722-2892

Consumers may file a written or verbal grievance at any time regarding the provision of mental health services. To file a grievance contact: UCF Operations Manager, fonda@ucfnv.org, 702-722-2440. The Operations Manager can help you fill out the Grievance Form.

Important Information You Should Know

1. If you need assistance with completing this form:

- You may ask any Intake Coordinator who is a staff person at each program or the Operations Manager to assist you.

2. You may authorize another person to act on your behalf if you sign a Release of Information form for that person to know confidential information.

3. You may, in addition to this form, submit written materials and present additional clinical or medical evidence in support of your position at the hearing.

4. Within sixty (60) working days of receipt of a grievance, the Operations Manager will review the grievance and provide a decision on the grievance. This timeframe may be extended by you for up to 14 days by request, or by United Citizens Foundation if it is determined that there is a need for additional information and that the delay is in the your interest.

5. Client/families will not be subject to any manner of discrimination, penalty, sanction or restriction for exercising their appeal rights.

6. For Additional information, please call:

- Fonda Tanner 702-722-2440

Acknowledgement Signature: _____

Printed Name: _____Date: _____

Witness Name & Signature: _____

PATIENT'S RIGHTS

As the patient of a program for treatment of abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1. If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.
2. You have the right to be provided treatment appropriate to your needs.
3. If you are transferred to another treatment provider, you have the right to be explained the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
4. You have the right to be informed of all program services, which may be of benefit to your treatment.
5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.
7. You have the right to be informed of our diagnosis, treatment plan and prognosis.
8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.
9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
10. You have the right to examine your bill for treatment and to receive an explanation of the bill.
11. You have the right to be informed of the program's rules for your conduct at the facility.
12. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
13. You have the right to receive respectful and considerate care.
14. You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.
15. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.
16. You have the right to safe, Healthful and comfortable accommodations.
17. You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you're are a patient.
18. Waiver of any civil or other right protected by law cannot be required as a condition of program services.
19. You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.

20. You have the right to attend religious activities of your choice, including visitation from a spiritual counselor, to the extent that such activities do not conflict with program activities. The program shall make a reasonable accommodation to your chosen religious activities. Attendance at and participation in any religious activity is to be only on a voluntary basis.
21. You have the right to grieve actions and decisions of facility staff, which you believe, are inappropriate, including but not limited to actions and decisions, which you believe violate your rights as a patient. The facility is obligated to develop a grievance procedure for timely resolution of complaints from patients and to post such a procedure in a place where it shall be immediately available to you. You have the right to freedom from retaliation or other adverse consequences as the product of filing a grievance. To report a grievance, please contact Daniel Avalos verbally 1-702-485-1259 or by written letter to 4485 S Buffalo Dr. Las Vegas, NV 89147.
22. You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints may be addressed in writing or by telephone to: Substance Abuse Prevention and Treatment Agency, 4126 Technology Way, 2nd Floor, Carson City, Nevada 89706. Phone: 1-775-684-4190
23. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

Patient acknowledgement:

I hereby acknowledge that I have read, understand, and have been provided a copy of the above Patient's Rights.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

UNITED CITIZENS FOUNDATION

PERMISSION TO CONTACT FORM

Client Name: _____

DOB: _____

I _____ give United Citizens Foundation, permission to contact me and or leave a message concerning appointments, administrative items, or emergency issues via the following methods (please check all methods that you approve and provide the appropriate contact information in the space provided):

Y	N	Voice Mail (home)	_____
Y	N	Voice Mail (cell)	_____
Y	N	Voice Mail (work)	_____
Y	N	Text Message (not encrypted)	_____
Y	N	Email (not encrypted)	_____
Y	N	Postal Mail (address)	_____
			_____
			_____

NOTE: Every attempt will first be made to contact you through the encrypted email system that meets HIPAA/HITECH regulations.

_____	_____
Parent / Client	Signature Witness
_____	_____
Printed name of Parent / Client	Printed Name of Witness
_____	_____
Date	Date