CAFA
...Making A Safer Place for Children

CAFA Patient Financial Information
MINOR
921 Country Club Road, Suite 222, Eugene, OR 97401
Phone: 541-686-6000 Fax: 541-344-8239

Therapist: _____ **Date of Initial Appointment:** _____

Child's Information

Name: Male / Female

Address:

(Street) (City) (State) (Zip)

Date of Birth:

Parent(s) /Guardian Information

Name:

Address:

(Street) (City) (State) (Zip)

Relationship to Child: Birth Date:

Home Phone: Cell Phone: Cell Provider:

Email:

Would you like to sign up for Text Reminders? Y / N

Insurance Information

Insurance Company Name:

Customer Service Phone:

Policy Holder's Name: DOB: Relationship to Client: Self / Spouse / Parent

Member/Subscriber ID Number: Group Number:

EAP Authorization Number:

(**Office Use**: Service Code: _____ Axis Code :_____)

Assignment of Insurance Benefits and Release of Information:
In the event that this office will be billing my insurance, I hereby authorize payment directly to the Provider of Service for benefits due for myself or my dependent and authorize release of information for the purposes of billing insurance and the coordination of benefits.
Fees: Initial Session: $250, Subsequent Individual Sessions: $115.00

Your Fee: _____
Fee is subject to increase with advance notice. Each therapy session will be scheduled for 50 minutes. Payment for therapy is expected at the time of treatment unless other arrangements have been made with the therapist. If insurance is billed, any deductibles and co-payments must be paid at the time services are rendered. We will co-operate in billing insurance, however, if your bill is not paid by your insurance company, YOU ARE RESPONSIBLE TO PAY YOUR BILL IN FULL. When an appointment time is made, the therapist's time and office space are naturally reserved for the scheduled therapy session. Because of this, ***the client will be charged for missed appointments if they are not canceled within 24 hours before the scheduled counseling appointment.*** Missed appointments are not covered by insurance. At times, the therapist will need to be available for the client outside of regularly scheduled appointment hours. This may include crisis intervention (including telephone conversations, unscheduled session, professional consultations, court proceeding, etc.) Clients are responsible for payment of the time spent by the therapist in such situations.

Signed: _____ Date: _____
My signature indicates that the above is true and that I also agree to the above terms

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Privacy Policy
Acknowledgement & Consent

I understand that **Christian As Family Advocates** will use and disclose health information about me. I understand that my health information may include information both created and received by the agency, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that **Christians As Family Advocates** may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related health information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the agency's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how **Christians As Family Advocates** will handle health information about me. This written description is known as a notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Christians As Family Advocates, and my rights regarding my health information.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that **Christians As Family Advocates** is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand that information above and that I have been offered the opportunity to have a copy of the Notice of Privacy Practices.

_____

Child's name (please print)

_____

Client's representative (please print) Representative signature

_____

Description of representative's authority:

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Acknowledgement of Access to Mental Health Declaration

I acknowledge that I have been given an opportunity to complete a declaration for mental health treatment. "Declaration for Mental Health Treatment" means a written statement of an individual's preferences concerning his or her mental health treatment. The declaration is made when the individual is able to understand and legally make decisions related to such treatment. It is honored, as clinically appropriate, in the event the individual becomes unable to make such decisions.

Copies of mental health declaration are offered at time of intake and are made accessible in CAFA's main office in the reception area.

I have been provided access to mental health declaration forms.

Client's Printed Name

Client Signature Date

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Website, Social Networking and Electronic Communication Policy

Our website, www.CAFAWeb.com, provides a valuable source of information for clients. We invite and encourage clients and families to review the website periodically since changes are common.

- **Christians As Family Advocates (CAFA)** maintains a professional presence on Facebook, and individual staff members may maintain professional and/or personal pages on Facebook, Twitter, LinkedIn or other social networks. Although our Facebook page and Twitter feeds are privacy-protected to the extent possible, individuals who choose to "like" or "follow" us on Facebook or Twitter are responsible for establishing their own privacy settings to protect themselves from the public identifying a relationship with **CAFA**.
- Counselors will not accept invitations to be "friends" on Facebook using their personal pages in keeping with maintaining professional boundaries with clients.
- With the availability of email and text messaging, sometimes clients may wish to communicate with **CAFA** staff electronically. Although our email accounts and cell phones are privacy-protected to the extent possible, individuals who elect to utilize such communication must recognize limited privacy protection for such communications. **CAFA** does not, at this time, have the capacity to utilize specially encrypted email.
- Additionally, it is essential that those who elect to communicate with **CAFA** staff utilizing email and/or text message understand our policy regarding such communication. Because our team members have full professional schedules, clinicians may only check email and/or text messages once or twice a day, Monday-Friday. Because we have full personal lives, we may not check email and/or text messages at all at night or on the weekends. It is up to the individual clinician if and when they reply to email/texts, and some staff may elect to wait to discuss the content of such communication in the next scheduled appointment. Therefore, clients should not necessarily expect a response to email or text message communications.
- In the event that a **CAFA** client experiences an emergency or crisis of any kind and needs a prompt response, email or text messages should not be used as the primary communication. In case of a medical emergency please call 911. In case of a mental health emergency, please call White Bird/Cahoots at (541) 342-8255.

By signing below, I agree that I have reviewed and understand that information above and that I have been offered the opportunity to have a copy of the Website, Social Networking and Electronic Communication Policy

Child's name (please print)

Client's representative (please print) Representative signature

Description of representative's authority:

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Grievance Policy

Christian's As Family Advocates' (CAFA) policy is to try and resolve issues quickly and in a manner that will promote consumer satisfaction. Clients of CAFA have a right to file a grievance without being afraid of threats or reprisals of any kind. Clients may request another CAFA staff person, family member, or other chosen advocate be present when a meeting is held to make or hear the grievance.

Grievance Procedures

1. Discuss concerns with your therapist or service provider who is your primary contact.
2. Discuss concerns with your therapist or service provider's supervisor.
3. Discuss concerns with the Director of Christian's As Family Advocates.
4. You may file a complaint either verbally or written to the Director or her designee.
5. After receiving the grievance, the Director or her designee will investigate the facts concerning the grievance. You will be notified of the findings of the investigation and your appeal rights within five (5) working days of the date of the presentation of the grievance; or you will be notified in writing of a delay in the decision and will be notified of the findings of the investigation and your appeal rights within 30 calendar days.

Start with step one and progress to the next step(s) as necessary until the matter is resolved.

Assistance and Resources

- CAFA will offer assistance in filing a grievance.
- There will be no retaliation for filing a grievance.
- LaneCare clients may ask for assistance from the LaneCare Ombudsperson. This person may be reached at 541-345-6466.
- You may also contact Disability Rights Oregon for assistance at 1-800-452-1694.

I have read and understand the above policy.

Child's Name (PLEASE PRINT)

Client's representative (please print) Representative signature

Witness (please print) Witness signature

Each client shall be given a copy of the Grievance Policy at the time of admission; a copy is kept in the client's chart. If a grievance is filed, a copy of the CAFA Grievance Process Form and information about resolution of the grievance is kept in the client's chart and the originals are filed with CAFA for quarterly reporting and quality assurance committee review.

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Child/Teen Assessment Form

1. Client Information

Client Name: Today's Date:

Date of Birth: Age: Gender: Grade:

School:

Is DHS Involved? ☐ Yes ☐ No

If yes, who is the caseworker?

Does the client have any disabilities? ☐ Yes ☐ No

If yes, what is the disability?

2. Emergency Contact Information

Name: Phone: Relationship:

Address:

Alternate Emergency Contact:

Name: Phone: Relationship:

Address:

3. Family Information

Name(s) of Sibling(s)	Age	Gender	Grade

Biological Mother's Name:

Biological Father's Name:

Step Mother's Name:

Step Father's Name:

Adoptive/Foster Parents' Names:

What are your family's strengths?

4. Cultural History

What is your family's ethnic/cultural background and religious background?

5. Educational History

Your child's academic level is: ☐ Above grade level ☐ At grade level ☐ Below grade level ☐ Well below grade level
In school, your child has: ☐ No behavior problems ☐ Frequent behavior problems ☐ Some behavior problems
Does your child currently receive services for special education? ☐ Yes ☐ No

6. Medical Information

Primary Care Physician: Phone:

Is child in good health? ☐ Yes ☐ No If no, please explain?

Has this child been hospitalized in her/his lifetime?
If yes, please explain:

Current Medications Prescribed by Physician:

Date of last physical:

7. Psychiatric/Mental Health History

Has your child, or anyone in your family, ever received counseling? ☐ Yes ☐ No
If so, who and when?

Has anyone in your family ever received medication or been hospitalized for mental health reasons ☐ Yes ☐ No
Has anyone in your family threatened or attempted suicide? ☐ Yes ☐ No
If yes, were they hospitalized? ☐ Yes ☐ No For how long? _____
Has a child or family member's drug or alcohol use caused problems in the family? ☐ Yes ☐ No
Has your child experienced any trauma? ☐ Yes ☐ No If yes, please explain:

If your child has been abused (sexually, physically, emotionally, verbally) please explain:

Has your child ever:
☐ Been cruel to animals ☐ Set fires ☐ Discusses plans to commit suicide ☐ Tried to hurt self
If so, please describe:

Why are you bringing your child to therapy?

Psychiatrist's Name: Phone:

Current Medications Prescribed by Psychiatrist: (Name, dose and purpose for each):

8. Behavioral History

Does your child have: *(Please check all that apply)*

□ Uncontrollable/hyperactive energy	□ Low energy/activity level	□ Irritable
□ Problems with concentration	□ Anxious and fearful thoughts	□ Eating problems
□ Hopeless feelings about the future	□ Motor skill delays	□ Compulsive behaviors
□ Hopeless feelings about self	□ Difficulty making friends	□ Crying spells
□ Sensitivity to noises, light or touch	□ Language delays	□ Special interests
□ Exaggerated startle response	□ Separation fears	□ Angry outbursts
□ Difficulty paying attention	□ Nightmares	□ Cutting
□ Irritable outbursts	□ Worries about germs	□ Sleeping problems
□ Obsessive thoughts	□ Suicidal thoughts	□ Social anxiety
□ Drug and/or Alcohol problems	□ Bed wetting	

9. Legal History

Has your child, or any family member, had legal problems or are involved in current legal proceedings? ☐ Yes ☐ No

If yes, please describe:

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Child/Teen Alcohol & Drug Assessment

To be completed by the child if possible

When did you have your last drink: _____

How often do you drink alcohol?

☐ Never ☐ Less than 1 time / month ☐ 2-3 times per week ☐ Daily

How much do you drink at a time?

☐ None ☐ 1-2 drinks per sitting ☐ 5+ drinks per sitting

How often are you intoxicated/drunk?

☐ Never ☐ Less than 1 time / month ☐ 2-3 times per week ☐ Daily

Which of the following describes your alcohol use? *Check all that apply*

☐ Do not drink alcohol ☐ Occasional or social ☐ Psychological dependence

☐ Addicted - cannot stop ☐ Don't want to stop ☐ Motivated to stop

Alcohol - Related Problems: C*heck all that apply*

☐ None ☐ School / Job Problems ☐ Sleep Disturbances ☐ Physical Withdrawal
☐ Hangovers ☐ Arrests ☐ Blackouts ☐ Medical Complications
☐ Assaults ☐ Passing Out ☐ Seizures ☐ Concern over Drinking
☐ Can't Stop after First Drink ☐ Binge Drinking ☐ Interpersonal Problems ☐ Changes in Tolerance

When did your drinking become a problem?

☐ No problems with alcohol ☐ In the last month ☐ 2-6 months ago ☐ More than one year ago
☐ More than 5 years ago

History of Treatment: *Check all that apply*

☐ None ☐ Stopped on own ☐ Attended AA / other 12-step program
☐ Outpatient program ☐ Inpatient Program
☐ Attended community-based program

Other Substance Use:

Check all substances used in the past 6 months & how often you use

☐ None ☐ Marijuana: ☐ Sedatives: ☐ Cocaine:
☐ Stimulants: ☐ Inhalants: ☐ Prescription Drugs: ☐ Hallucinogens:
☐ Opiates: ☐ Caffeine: ☐ Tobacco: ☐ Other:

Have your pursued treatment for the use of any of these substances?

☐ Outpatient program ☐ Inpatient program

Childhood Depression Inventory

Amen Clinic Learning Disability
Child/teen

Name:_____
Date:_____
Instructions:
Kids sometimes have different feelings and ideas.
This form lists the feelings and ideas in groups of three statements. From each group pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, then go on to the next group of three statements.

There is no right or wrong answer. Put the mark in the box next to the sentence that you pick.
Here is an example how this form works. Try it, put a mark next to the sentence that describes you best.

Example

☐ I read books all the time.
☐ I read books once in a while.
☐I never read books.

Remember, pick out the sentences that describe your feelings and thoughts in the past two weeks.

1. ☐ I am sad once in a while.
   ☐ I am sad many times.
   ☐ I am sad all the time.

2. ☐ Nothing will ever work out for me.
   ☐ I am not sure if things will work out for me.
   ☐ Things will work out for me O.K.

3. ☐ I do most things O.K.
   ☐ I do many things wrong.
   ☐ I do everything wrong.

4. ☐ I have fun in many things.
   ☐ I have fun in some things.
   ☐ Nothing is fun at all.

5. ☐ I am bad all the time.
   ☐ I am bad many times.
   ☐ I am bad once in a while.

6. ☐ I think about bad things happening to me once in a while.
   ☐ I worry that bad things will happen to me.
   ☐ I am sure that terrible things will happen to me.

7. ☐ I hate myself.
   ☐ I do not like myself.
   ☐ I like myself.

8. ☐ All bad things are my fault.
   ☐ Many bad things are my fault.
   ☐ Bad things are not usually my fault.

9. ☐ I do not think about killing myself.

☐ I think about killing myself but would not do it.
☐ I want to kill myself.

10. ☐ I feel like crying every day.
☐ I feel like crying many days.
☐ I feel like crying once in a while.

11. ☐ Things bother me all the time.
☐ Things bother me many times.
☐ Things bother me once in a while.

12. ☐ I like being with people.
☐ I do not like being with people many times.
☐ I do not want to be with people at all.

13. ☐ I cannot make up my mind about things.
☐ It is hard to make up my mind about things.
☐ I make my mind about things easily.

14. ☐ I look O.K
☐ There are some bad things about my looks.
☐ I look Ugly.

15. ☐ I have to push myself all the time to do my schoolwork.
☐ I have to push myself many times to do my schoolwork.
☐ Doing schoolwork is not a big problem.

16. ☐ I have trouble sleeping every night.
☐ I have trouble sleeping many nights.
☐ I sleep very well.

17. ☐ I am tired once in a while.
☐ I am tired many days.
☐ I am tired all the time.

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____

Date: _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1. I worry about things.....	Never	Sometimes	Often	Always
2. I am scared of the dark.....	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach.....	Never	Sometimes	Often	Always
4. I feel afraid.....	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home.....	Never	Sometimes	Often	Always
6. I feel scared when I have to take a test.....	Never	Sometimes	Often	Always
7. I feel afraid if I have to use public toilets or bathrooms.....	Never	Sometimes	Often	Always
8. I worry about being away from my parents.....	Never	Sometimes	Often	Always
9. I feel afraid that I will make a fool of myself in front of people.....	Never	Sometimes	Often	Always
10. I worry that I will do badly at my school work.....	Never	Sometimes	Often	Always
11. I am popular amongst other kids my own age.....	Never	Sometimes	Often	Always
12. I worry that something awful will happen to someone in my family.....	Never	Sometimes	Often	Always
13. I suddenly feel as if I can't breathe when there is no reason for this....	Never	Sometimes	Often	Always
14. I have to keep checking that I have done things right (like the switch is off, or the door is locked).....	Never	Sometimes	Often	Always
15. I feel scared if I have to sleep on my own.....	Never	Sometimes	Often	Always
16. I have trouble going to school in the mornings because I feel nervous or afraid.....	Never	Sometimes	Often	Always
17. I am good at sports.....	Never	Sometimes	Often	Always
18. I am scared of dogs.....	Never	Sometimes	Often	Always
19. I can't seem to get bad or silly thoughts out of my head.....	Never	Sometimes	Often	Always
20. When I have a problem, my heart beats really fast.....	Never	Sometimes	Often	Always
21. I suddenly start to tremble or shake when there is no reason for this...	Never	Sometimes	Often	Always
22. I worry that something bad will happen to me.....	Never	Sometimes	Often	Always

Client Name _____ *DOB:* _____

23. I am scared of going to the doctors or dentists.....	Never	Sometimes	Often	Always
24. When I have a problem, I feel shaky.....	Never	Sometimes	Often	Always
25. I am scared of being in high places or lifts (elevators).....	Never	Sometimes	Often	Always
26. I am a good person.....	Never	Sometimes	Often	Always
27. I have to think of special thoughts to stop bad things from happening (like numbers or words).....	Never	Sometimes	Often	Always
28 I feel scared if I have to travel in the car, or on a Bus or a train.....	Never	Sometimes	Often	Always
29. I worry what other people think of me.....	Never	Sometimes	Often	Always
30. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds).....	Never	Sometimes	Often	Always
31. I feel happy.....	Never	Sometimes	Often	Always
32. All of a sudden I feel really scared for no reason at all.....	Never	Sometimes	Often	Always
33. I am scared of insects or spiders.....	Never	Sometimes	Often	Always
34. I suddenly become dizzy or faint when there is no reason for this.....	Never	Sometimes	Often	Always
35. I feel afraid if I have to talk in front of my class.....	Never	Sometimes	Often	Always
36. My heart suddenly starts to beat too quickly for no reason.....	Never	Sometimes	Often	Always
37. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of.....	Never	Sometimes	Often	Always
38. I like myself.....	Never	Sometimes	Often	Always
39. I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).....	Never	Sometimes	Often	Always
41. I get bothered by bad or silly thoughts or pictures in my mind.....	Never	Sometimes	Often	Always
42. I have to do some things in just the right way to stop bad things happening.....	Never	Sometimes	Often	Always
43. I am proud of my school work.....	Never	Sometimes	Often	Always
44. I would feel scared if I had to stay away from home overnight.....	Never	Sometimes	Often	Always
45. Is there something else that you are really afraid of?.....	YES	NO		
Please write down what it is _____				
How often are you afraid of this thing?.....	Never	Sometimes	Often	Always

C 1994 Susan H. Spence

Client Name _____ *DOB:* _____