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

Therapist: ____ **Date of Initial Appointment: _______________**

Client Information

Name: Date of Birth: Gender: Male Female

Address:

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

Home Phone: Cell Phone: Cell Provider:

Would you like to sign up for Text Reminders? Please provide cell provider (above) Y / N

Email:

Relationship/Marital Status: Ages of Children:

Medicare & Medicare Supplement Plans:

Our office is **not** a participating provider with Medicare, therefore, we are unable to bill Medicare or Medicare Supplement Plans on your behalf.

Insurance Information

Insurance Company Name:

Customer Service Phone:

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

Subscriber's Address (if different from above):

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 <u>I have been offered the opportunity to have a copy of the Notice of Privacy Practices.</u>

____

Client's name (please print) Client's signature

____

Client's representative (please print) Representative signature

____

Description of representative's authority:

Client Name ______________________ *DOB* ______________________

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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.

____

Client's name (please print) Client's signature

____

Client's representative (please print) Representative signature

____

Description of representative's authority:

Client Name ______________________ *DOB* ______________

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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.

____

Name (PLEASE PRINT) (first, middle, last)

____

Client Signature Date Witness Signature Date

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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ACES Screening

While you were growing up, during your first 18 years of life:	**If yes mark 1.**
1) Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	
2) Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	
3) Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?	
4) Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	
5) Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	
6) Were your parents ever separated or divorced?	
7) Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	
8) Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	
9) Was a household member depressed or mentally ill or did a household member attempt suicide?	
10) Did a household member go to prison	
ACE Score:	

Client Name ______________________ *DOB* ______________

Date:

Name: ______ Marital Status: ______ Age: ______ Sex: ______

Occupation: ______ Education: ______

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

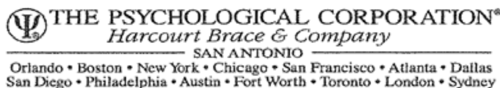
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

______ Subtotal Page 1

Continued on Back



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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Subtotal Page 1 ________
Subtotal Page 2 ________

Total Score ________

Client Name ____________________ *DOB* ____________________

CAFA
...Making A Safer Place for Children
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Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully ready each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me	Moderately, it wasn't pleasant at times	Severely, it bothered me a lot
Numbness of tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky/Unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint/Lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/Cold sweats	0	1	2	3
Column Total				

Scoring – Add each column, then add the column totals to achieve a grad score. Write that score here: __________

Interpretation

A grand sum **between 0-21** indicates very low anxiety. This is usually a good thing. However, it is possible that you might be unrealistic in either your assessment, which would be denial, or that you have learned to 'mask' the symptoms commonly associated with anxiety. Too little 'anxiety' could indicate that you are detached from yourself, others or your environment.

A grand sum **between 22-35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolves. Clearly, it is not 'panic' time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a counselor if the feelings persist.

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Adult Checklist of Concerns

Client Name: ____Date:__________________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. **(For a child, mark any of these and then complete the "Child Checklist of Characteristics.")**

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, under eating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings

- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns . . . ")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholic/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:
- ❑ ____
- ❑ ____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

____

This is a strictly confidential patient medical record. Disclosure is expressly prohibited by law.

FORM 29. Adult checklist of concerns. From The Paper Office. Copyright 2003 by Edward L. Zuckerman. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

Client Name ____ *DOB* ____________________