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) / Caregiver 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 Email/Text Reminders? Y / N

Insurance Information

Insurance Company Name:

Customer Service Phone:

Policy Holder's Name: 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 <u>I have been offered the opportunity to have a copy of the Notice of Privacy Practices.</u>

Child's name (please print)

Client's representative (please print) Representative signature

Description of representative's authority:

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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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Choate Depression Inventory for Children (CDIC)

To be filled out by the child if possible

Please rate how often these statements are true for the child: 1= never, 2= often, 3 = a lot

I feel sad lots of the time	1	2	3
I have trouble sleeping	1	2	3
I feel tired lots of the time	1	2	3
I don’t have many friends	1	2	3
I cry a lot	1	2	3
I don't like playing with other kids	1	2	3
I don't feel as hungry as I used to	1	2	3
Other kids don't like me	1	2	3
I feel lonely	1	2	3
I have lots of headaches and stomachaches	1	2	3
I don't like school	1	2	3
I have bad dreams	1	2	3
Sometimes I think about hurting myself	1	2	3
I worry a lot	1	2	3
I don't like myself	1	2	3
Other kids have more fun that I do	1	2	3
I don't do as well in school as I used to	1	2	3
Sometimes I have trouble concentrating	1	2	3
I feel angry lots of the time	1	2	3
I get into lots of flights	1	2	3

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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: *Check 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