Upland Hills® Health

Name:		Todays Date:
DOB:	Age:	Marital Status:
Address: City: Zip Code:		SSN: Home Phone: Cell Phone:
Gender: ☐ Male ☐ Female ☐ Transgender		Email Address:
Were you referred to UHH Behavioral Counseling? If so, by whom?		

In the event of an emergency, call:

Name:	Relationship to client:
Home Phone:	Cell Phone:

What is the primary reason you are seeking services today?
(check all those that apply)

☐ Depressed	☐ Agitated/Restless	☐ Anxious	☐ Confused	☐ Bored
☐ Fearful	☐ Angry	☐ Ashamed	☐ Hostile	☐ Hopeless
☐ Marital/Relationship	☐ Parenting/Child	☐ Divorce/Seperation	☐ Other Family issues	☐ Emotional/Psychological
☐ Sex	☐ Work Related	☐ I need a referral	☐ I am in Crisis	☐ I need medication
☐ Someone close to me needs help	☐ It would help to talk to someone	☐ Grief & Loss	☐ Other	☐ Financial
☐ School	☐ Memory	☐ Religious	☐ Health	☐ Drug/Alcohol

Are you considering doing harm to yourself or others? ☐ Yes ☐ No
Please Explain:

For you to consider your counseling experience successful, what are you hoping to accomplish? Please Explain:

Ongoing Medical conditions: (i.e. asthma, high blood pressure, diabetes, chronic pain etc.)

Please list your Doctors/Therapists/All Other Patient Providers (include the person who prescribes your medications)

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

What medications are you currently prescribed? ☐ **None**

Medication:	Dose: (important)	How long at dose:	What is the medication for?

Is there a history of mental illness in your family? ☐ Yes ☐ No

Please Explain: (specify which relative and what the diagnosis is)

Legal

Are you here because of a current domestic related charge? ☐ Yes ☐ No	
List violations beginning with the most current:	
Current charge:	Date:
Court:	Result of charges (indicate if they are pending):
Have you ever been convicted of a felony? ☐ Yes ☐ No	Are you presently on parole or probation? ☐ Yes ☐ No

Patient's Consent for Treatment

Signature(s) required below to accept and begin treatment

Upland Hills Health, in the consent for treatment document can be defined as the inclusion of all clinicians which provide counseling services for Upland Hills Health patients.

Unless otherwise indicated, I have voluntarily chosen to seek services at Upland Hills Health Behavioral Health Counseling. I understand I may refuse or withdraw consent for receiving counseling before counseling is initiated. I understand that confidentiality will be held and released in accordance with those laws, which regulate the confidentiality of records and information. State and local laws require my counselor to report all cases where:

- **Physical or sexual abuse or neglect of minors or elderly exists.**
- **Where there exists a danger to oneself or others.**

I understand Upland Hills Health takes all precautions to safeguard confidentiality. Patients will not be photographed but will be required to provide photo identification such as a driver's license at time of intake service. Where client services are reimbursed and/or overseen by insurance companies, managed care companies and plan administrators, Upland Hills Health Behavioral Health Counseling may be required as a condition of providing these services, to report information to case managers and/or other principals in the above-mentioned organizations. Further, if information that Upland Hills Health transmits through facsimile and/or telephonic voice mail, answering machine, email or text message is intercepted by any unauthorized people or entities, the client waives any and all claims to breach of confidentiality. Upland Hills Health may contact me in any of the ways I have provided unless I have otherwise stated.

Termination: I have the right to terminate treatment at any time. Upland Hills Health may terminate treatment with me if payment is not made, or if there is a refusal to follow therapeutic recommendations (such as remaining sober, filling prescriptions, etc.) If this occurs, I will be provided a recommendation for continued care.

This notice is effective March 25, 2022 and Upland Hills Health are required to abide by terms of the Notice of Privacy Practices currently in effect. Upland Hills Health reserves the right to change the terms of its Notice of Privacy practices and to make the new notice provisions effective for all protected health information that Upland Hills Health maintains.

Consent for treatment of Minor(s) (under 18 years old)

I, (parent or legal guardian's name)_____, give my permission to Upland Hills Health to provide counseling services for my child(ren). My signature further indicates that I am the legal guardian and am authorized to give this consent.

Parent/Guardian's Signature: _____ Date: _____

Area below is to be completed when you meet with your counselor ONLY. Thank You

This section must be completed and signed by the counselor and patient prior to starting service. Counselor: Please check each item below to verify the following information has been explained and that a COPY of each item listed below has been distributed to the client.

1. Patient has read and understands the above.
2. Patient has received a copy of the Patient's Rights.
3. Patient understands the limits of their financial responsibility for services provided, and acknowledges receiving a copy of the Financial Policies Agreement.
4. Patient has received a copy of the Notice of Privacy Practices (HIPAA compliance effective 9/1/2010).
5. Patient has received a copy of telephone numbers and addresses for Adult and Child Protective Services, Division of Behavioral Health Services.
6. Patient has received a copy of the Grievance Policy.

Signatures required below to confirm understanding and acknowledgment of receipt of all the above.

Patient or Guardian Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Print Counselor Name/Credentials: _____

Save form and send to the Behavioral Health Staff at: behavioralhealth@uplandhillshealth.org. Or print and give to your Counselor.