# Intake Checklist and Signature Page

**Please Check all boxes when each form is signed, and to verify all forms are in packet**

Please Check off and initial the Rights and Policies below. Initial

- ☐ I have read the SSBHC Agency Policy..... ☐
- ☐ I have read the Client Rights..... ☐
- ☐ I have read the Summary of Privacy Practices ..... ☐
- ☐ I have read the deductible agreement..... ☐
- ☐ I have read and consent to treatment at SSBHC..... ☐
- ☐ I have read and consent to SSBHC no show policy..... ☐
- ☐ I have read the informed consent for treatment at SSBHC..... ☐

Client: _____ Date: _____
(print name)

Client/Parent/Guardian: _____ Date: _____
(Signature)

Therapist: _____ Date: _____
(Signature)

I have read all the policies above, and by signing below I acknowledge receipt of copies of the above policies.

Give to Clients

- ☐ SSBHC Agency Policy
- ☐ Summary of Privacy Practices
- ☐ Clients Rights

Place in Client Folder

- ☐ Credit Card Auth (if applicable)
- ☐ Couples Release (if applicable)
- ☐ Consent for Treatment in School setting (if applicable)
- ☐ Deductible Agreement
- ☐ Emergency Contact / Phone List Form
- ☐ Authorization to Obtain/Release PHI (2 sided) MBHP Med Communication Form

# South Shore Behavioral Health Clinic

## Clients Rights, Responsibilities and Consent

Clients Rights

1. **South Shore Behavioral Health Clinic** provides evaluations and counseling by medical health professionals including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and masters level clinicians. As a client you have the right to services which are provided in a professional manner.
2. If you feel that an evaluation was not explained fully, or that psychotherapy is not being provided as agreed upon, please first discuss it with your therapist. If you are not satisfied, you may write or call the Site Director at the site your services are provided.

Clients Responsibilities

1. Payment of the clinical fee is the responsibility of the client, and is due at the time the service is rendered. Clinical policy prohibits scheduling further appointment when there is an overdue balance.
2. When partial or full payment is available through medical insurance plans, the client may defer payment of part or all of the fee. Any portion of the fee not covered must be paid in *full by* the client at the time the service is rendered.
3. When third party payment is uncertain, as with certain commercial insurance plans, the fee must be paid in full by the client until *the third* party payment is received. Any resulting overpayment will be reimbursed or credited to client's account.
4. Repeated cancellations or no-shows may result in termination of service.

Client Consent and Authorization

- I authorize **South Shore Behavioral Health Clinic** to release information necessary to process insurance claims.
- I authorize **South Shore Behavioral Health Clinic** to provide information to the managed care company (when relevant) for purposes of outpatient services authorization.

❑ **I hereby give consent for outpatient treatment and understand that I may rescind this authorization and terminate care at any time, with or without prior notice.**

- *I hereby authorize my* insurance carrier to pay **South Shore Behavioral Health Clinic** directly for services rendered.
- I have received and understand my Clients Rights as contained in Massachusetts General Law, Section 70E of Chapter 111.
- I understand that information about me will be kept confidential and will not be released without my consent except in specific circumstances which have been explained to me. I understand that the primary clinician assigned to my care by **South Shore Behavioral Health Clinic** may discuss that care with other persons employed by or consulting to **South Shore Behavioral Health Clinic** for purposes of supervision, guidance and consultation regarding my care.

## Contacts and Resources

| Name role | Phone | Name role | Phone |
|---|---|---|---|
| | # | | # |
| | # | | # |
| | # | | # |

## Notes:

## Goal of Plan

## Actions

Developed by:

Date Completed ___/___/___ ☐ Initial ☐ Revision

Shared With:

☐ _____

☐ _____

☐ _____

☐ _____

This plan is for

___/___/___ _____ _____

Date of birth First name Last name

(other information, needs, requests)

_____ _____ ph: _____ ph: _____

Printed name of the Parent/Guardian, if applicable

_____ _____ ph: _____ ph: _____

Printed name of the Parent/Guardian, if applicable

| Person's Name (First MI Last): | Record #: | Date of Admission: |
|---|---|---|
| **Organization/Program Name:** South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic | DOB: | Gender: ☐ Male ☐ Female ☐ Transgender |

**Safety and Protective Factors:** Indicate below if the person is currently engaged with any Safety and Protective Activities. Comment on each "Yes" answer.

| *These factors often support individuals with self-management of risk issues. Many of these factors are found elsewhere in the assessment but repeated here for ease of formulating concerns about risk.* | Yes | No | Not Known | Comments and/or Context |
|---|---|---|---|---|
| Stable Housing | ☐ | ☐ | ☐ | |
| Stable Employment | ☐ | ☐ | ☐ | |
| Has Income/ Insurance/ Benefits | ☐ | ☐ | ☐ | |
| Has Positive Alliance with Service Providers | ☐ | ☐ | ☐ | |
| Experience Positive Benefits from Treatment | ☐ | ☐ | ☐ | |
| Seeks Assistance When at Risk/ In Danger | ☐ | ☐ | ☐ | |
| Had Developed a Crisis/Safety Plan/ WRAP Plan/ Self Care Plan | ☐ | ☐ | ☐ | |
| Medication Adherence | ☐ | ☐ | ☐ | |
| Able to Plan and Follow Through | ☐ | ☐ | ☐ | |
| Capacity for Empathy / Perspective Taking | ☐ | ☐ | ☐ | |
| Religious / Spiritual Beliefs or Involvement | ☐ | ☐ | ☐ | |
| Stable / Positive Personal Relationships | ☐ | ☐ | ☐ | |
| Positive Family Supports / Has Children or Pets | ☐ | ☐ | ☐ | |
| Has Insight About Her/His Symptoms | ☐ | ☐ | ☐ | |
| Sobriety / No Active Substance Use | ☐ | ☐ | ☐ | |
| Low Psychosocial Stressors | ☐ | ☐ | ☐ | |
| Capacity to Weigh Risks and Benefits of Decisions | ☐ | ☐ | ☐ | |
| Capacity for Emotional Self-Regulation | ☐ | ☐ | ☐ | |
| Capacity for Self-Management of Behaviors | ☐ | ☐ | ☐ | |
| Future Orientation / Goals | ☐ | ☐ | ☐ | |
| Recovery Orientation | ☐ | ☐ | ☐ | |

**Risk Factors:** Indicate below if the person has any past or current risk factors relating to the category. For each item marked "past" or "current," please note the context of the risk factor and any other relevant information regarding its occurrence. If there is current presentation of an acute risk, such as suicidal ideation, homicidal ideation, etc., please refer to agency specific protocols.

| ***Harm to Others Factors*** | Past | Current | None | Comments and/or Context |
|---|---|---|---|---|
| Thoughts / Plans for Harming / Killing Others | ☐ | ☐ | ☐ | |
| Direct Violent Thoughts | ☐ | ☐ | ☐ | |
| Indirect Threats Implying Violence | ☐ | ☐ | ☐ | |
| Verbal Aggression that Precedes Violence | ☐ | ☐ | ☐ | |
| Serious Property Damage | ☐ | ☐ | ☐ | |
| Physical Assault / Violence to Others | ☐ | ☐ | ☐ | |
| Sexual Assault Against Others | ☐ | ☐ | ☐ | |
| Illegal or Antisocial Behaviors / Arrest / Conviction / NGRI / Incarceration | ☐ | ☐ | ☐ | |
| Neglect or Abuse of Dependents | ☐ | ☐ | ☐ | |
| Stalking / Restraining Order / Obsession Targeted at a Particular Person | ☐ | ☐ | ☐ | |
| Arson / Fire Setting / Fire Safety Issues | ☐ | ☐ | ☐ | |
| Extreme Paranoia / Perception of Threats / Command Hallucinations to Harm Others | ☐ | ☐ | ☐ | |
| Failure of Prior External Supervision to Control or Reduce Harm to Others | ☐ | ☐ | ☐ | |
| Other Harm or Danger to Others Issues: | ☐ | ☐ | ☐ | |
| Other Harm or Danger to Others Issues: | ☐ | ☐ | ☐ | |

| Person's Name (First MI Last): | Record #: |
|---|---|

| *Self-Harm Factors* | Past | Current | None | Comments and/or Context |
|---|---|---|---|---|
| Suicidal Thoughts / Plans / Rehearsal Behaviors | ☐ | ☐ | ☐ | |
| Suicide Attempts | ☐ | ☐ | ☐ | |
| Self-Harm Behaviors | ☐ | ☐ | ☐ | |
| Family History of Suicidal / Self-Harm | ☐ | ☐ | ☐ | |
| Life Threatening Eating Disorder | ☐ | ☐ | ☐ | |
| Victimized by Others / Places Self in Danger | ☐ | ☐ | ☐ | |
| Command Hallucinations for Self-Harm | ☐ | ☐ | ☐ | |
| Elopement Without Ability to Self-Preserve | ☐ | ☐ | ☐ | |
| Other Self-Harm: | ☐ | ☐ | ☐ | |
| Other Self-Harm: | ☐ | ☐ | ☐ | |
| Other Self-Harm: | ☐ | ☐ | ☐ | |

| ***Other Risk Factors***<br>*These factors may increase the level of concern a clinician has regarding potential risk* | Past | Current | None | Comments and/or Context |
|---|---|---|---|---|
| Recent Significant Loss | ☐ | ☐ | ☐ | |
| Memory Impairment / Dementia / Disorientation | ☐ | ☐ | ☐ | |
| Developmental Disability / PDD Spectrum | ☐ | ☐ | ☐ | |
| Young Age at Time of First Violent Behavior | ☐ | ☐ | ☐ | |
| Early Attachment Issues | ☐ | ☐ | ☐ | |
| Traumatic Brain Injury | ☐ | ☐ | ☐ | |
| Cognitive Impairment / Learning Disability | ☐ | ☐ | ☐ | |
| Extreme Impulsivity | ☐ | ☐ | ☐ | |
| Presents with Trauma Related Symptoms | ☐ | ☐ | ☐ | |
| Lack of Empathy / Remorse When Aggressive | ☐ | ☐ | ☐ | |
| Injury to Animals | ☐ | ☐ | ☐ | |
| Positive Views of Criminal Behavior | ☐ | ☐ | ☐ | |
| Requires Substitute Decision Making | ☐ | ☐ | ☐ | |
| Access to / Keeping / Carrying / Using Weapons | ☐ | ☐ | ☐ | |
| Non-Violent Problematic Sexual Behavior | ☐ | ☐ | ☐ | |
| Person is Actively Abusing Substances | ☐ | ☐ | ☐ | |
| Increased Risk Associated with Presence of Psychiatric Symptoms | ☐ | ☐ | ☐ | |
| Unwilling / Unable to Engage in Shared Risk Decisions / Risk Reduction Efforts | ☐ | ☐ | ☐ | |
| Chronic Medical Illness or Chronic Pain | ☐ | ☐ | ☐ | |
| Unable / Unwilling to Manage Risks | ☐ | ☐ | ☐ | |
| Experiencing Acute High Stress Situation | ☐ | ☐ | ☐ | |

**Summarize the Risk and Protective Factors and Indicate if Further Planning is Needed per Agency Protocols:**

| **Person's Signature** (Optional, if clinically appropriate): | **Date:** | **Parent/Guardian Signature** (If appropriate): | **Date:** |
|---|---|---|---|
| **Clinician/Provider - Print Name/Credential:** | **Date:** | **Supervisor - Print Name/Credential** (if needed): | **Date:** |
| **Clinician/Provider Signature:** | **Date:** | **Supervisor Signature** (if needed): | **Date:** |
| **Psychiatrist/MD/DO** (If required): | **Date:** | | |

**South Shore Center for Wellness LTD**
**DBA South Shore Behavioral Health Clinic**
200 Cordwainer Drive Suite 200 Norwell MA 02061
Tel: 781-878-8340

# Authorized Phone Numbers to Contact Clients

Home: _____ is it ok to leave message _____ yes _____ No

Work: _____ is it ok to leave message _____ yes _____ No

Cell: _____ is it ok to leave message _____ yes _____ No

Spouse: _____ is it ok to leave message _____ yes _____ No

Texting Number : _____ it is ok to text _____ yes _____ No

Email _____ is it ok to leave message _____ yes _____ No

I _____ hereby authorize you to call the above numbers checked yes to contact me, leave me a voice message, Email, or contact be by Text.

Client: _____ Date : _____

Witness: _____ Date: _____

**South Shore Behavioral Health Clinic**
**CLIENT CONSENT FORM**

**COUNSELING** is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

**CONFIDENTIALITY:**

**All interactions with South Shore Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.**

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety under the "Duty to Warn, Duty to Care Law" MGL Chap 123, sec 36B..

- Massachusetts state law requires that staff of the **South Shore Behavioral Health Clinic** who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.

- A court order, issued by a judge, may require the **South Shore Behavioral Health Clinic** staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us, or your therapist if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

---

**I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the South Shore Behavioral Health Clinic**

.

_____ _____

*Signature of Client* *Signature of Therapist*

_____

*Date*

# South Shore Behavioral Health Clinic

## Clients Rights, Responsibilities and Consent

### Clients Rights

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- I understand that information about me will be kept confidential and will not be released without my consent except in specific circumstances which have been explained to me. I understand that the primary clinician assigned to my care by **South Shore Behavioral Health Clinic** may discuss that care with other persons employed by or consulting to **South Shore Behavioral Health Clinic** for purposes of supervision, guidance and consultation regarding my care.

Print Name of Client _____

_____

Client / or Legal Guadian Signatur Date

_____

Witness Date

# South Shore Behavioral Health Clinic

## Initial Assessment Questions

1. Where would you/your family like to be in your life? (vision statement)

2. What gets in the way? (Needs, Challenges, Obstacles)

3. What helps you get there? (Strengths, Supports)

4. What needs to happen next? (Prioritized Needs, Plan)

# AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:_____ - _____Date of Birth:_____
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____

Print Name of Provider You are asking for records or speak to

Address: _____

Print Address of Provider

*My health information may be disclosed under this Authorization to:*

To the Recipient: South Shore Center for Wellness LTD _____

Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information

Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

*My health information may be disclosed under this Authorization to:*

To the Recipient: _____

Organization to receive the information Print Name of Individual to receive information

Address: _____

Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (I) this test is ordered, performed, or reported and ([I) the test results are positive or negative.
- Information regarding the results of a genetic test.

# AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:_____ Date of Birth: _____
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

_____

❑ Specific health information including only:

_____

*Note: Describe the health information to be excluded or included in a specific and meaningful fashion.*

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)_____

_____

; or _____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

*Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment*

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: _____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1._____ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2._____ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3._____ I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. I further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_____ Date: _____

Print Full Name of Person Served:_____

Relationship of Representative to Person Served:_____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

**South Shore Behavioral Health Clinic**
200 Cordwainer Drive, Suite 200 Norwell, MA. 02061
109 Rhode Island Road, Lakeville MA 02347
Tel: 781-878-8340

# SSBHC Agency Policy

- If you are seeing another therapist or professional, or another agency that results in non-payment of services you will be responsible for the charges incurred.
- Paperwork requested that is not to another mental health agency, physician, or mental health professional will be at a charge of $1.00 per page, for copies. Letters will be at $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist. Correspondence to attorneys or certain agencies are not covered by insurance and are subject to the above fees.
- Any paperwork for services not covered by insurance will be subject to $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist letters, and evaluations.
- Any client that is under the influence of Alcohol or Illegal Drugs that impair their therapy session will result in termination of the session. The session may be rescheduled at the discretion of the therapist and supervisor.
- Dissemination of Mental Health Records are at the discretion of the Supervisor or Medical Director, unless the records are for another Hippa Compliant Mental Health Agency, Licensed therapist, Medical Professional, Psychological Evaluation, or By Subpoena signed by a Judge.
- Cancellation policy requires that a client call with at least 24 hour notice to avoid cancellation fee if without appropriate notice. A fee of $75.00 dollars for a therapist, and $250.00 dollars for the Psychiatrist or Psychologist will be incurred without appropriate notice. Multiple cancellations without notice may result in discontinuation of services with the therapist. Psychiatric Appointments that are repeatedly cancelled or no showed may result in termination of psychiatric services.
- The Client is responsible to notify the Agency Immediately of any changes in insurance, such as new insurance provider, cancellation of policy, Any charges incurred due to cancellation of insurance, changing of policy without notice will be the responsibility of the client or responsible party.

# South Shore Behavioral Health Clinic

## New Intake Instructions

1. New clients are required to fill out new client intake packet in it's entirety, and return it to the office within 10 days
    a. Packets can be mailed out from our office
    b. Packets can be downloaded from our website - https://southshorecounselingandassociates.com or South Shore Behavioral Health Clinic.com
2. Completed packets must be:
    a. Filled out by the client's Parent or guardian for clients under 18 years old. *(note: for clients in DCF custody, Foster Care or Guardianship, proof of permission to sign must be included with submitted paperwork)*
    b. Must Signed by a witness (any adult other than the person signing the consents)
    c. A copy of the photo ID of the person filling out the paperwork must be submitted with the paperwork and a copy of the insurance card of the patient to be treated.
3. Packets can be returned in the following manner, and must be received within 10 days in order to continue services. For clients with packets not returned within 10 days, services will be paused until packet is received.
    a. Mailed to:
    South Shore Behavioral Health Clinic
    C/O Intake
    200 Cordwainer Drive
    Suite 200
    Norwell, MA 02061
    b. Faxed to:
    Attn: Intake
    (339)788-9904
    c. Securely Emailed to intake@ssbhc.com
    Most email servers are not HIPPA compliant, meaning that information sent via email may be susceptible to data breach and or data loss. This method is not recommended, and may be used at client's own liability.
    For those choosing to email documents, they must be password protected.

# South Shore Behavioral Health Clinic

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    a. Packets can be mailed out from our office
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    a. Filled out by the client's Parent or guardian for clients under 18 years old. *(note: for clients in DCF custody, Foster Care or Guardianship, proof of permission to sign must be included with submitted paperwork)*
    b. Must Signed by a witness (any adult other than the person signing the consents)
    c. A copy of the photo ID of the person filling out the paperwork must be submitted with the paperwork and a copy of the insurance card of the patient to be treated.
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    a. Mailed to:
    South Shore Behavioral Health Clinic
    C/O Intake
    200 Cordwainer Drive
    Suite 200
    Norwell, MA 02061
    b. Faxed to:
    Attn: Intake
    (339)788-9904
    c. Securely Emailed to intake@ssbhc.com
    Most email servers are not HIPPA compliant, meaning that information sent via email may be susceptible to data breach and or data loss. This method is not recommended, and may be used at client's own liability.
    For those choosing to email documents, they must be password protected.

# Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**Emergency Protocols**

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

South Shore Behavioral Health Clinic
200 Cordwainer Drive, Suite 200 Norwell MA 02061
109 Rhode Island Road Suite A, Lakeville MA 02347
Tel: 781-878-8340 Fax - 339-788-9904

# Therapeutic Mentor Emergency Protocol and Contact List

Emergency Contact: _____ Number: _____
(Name and Relation to Child)

Alternate Emergency Contact: _____ Number: _____
(Name and Relation to Child)

Parent/Caregiver Contact (if different from above): _____
Number: _____

Child's Insurance Carrier: _____ Insurance Number: _____

---

## Emergency Protocol

1. Make an attempt to calm the child using verbal de-escalation techniques before initiating emergency procedures.
2. If the child can be calmed via de-escalation techniques, return the child to their home and debrief the parent on the situation.
3. If the child is verbally, and/or physically aggressive, and/or defiant and cannot be transported, call the emergency contact above to come and assist their child.
4. Never transport a child who is escalated (as defined in number 3).
5. If the above contacts cannot be reached and de-escalation techniques are ineffective, and/or the child, clinician and/or the community is at harm, **call 911 immediately.**
6. If the child, clinician and/or community is at harm, **call 911 immediately** and skip all previous steps.
7. After calling 911 re-contact the parent/caregiver to give information.

Client: _____ Date: _____
Print Client Name

Parent/Guardian: _____ Date: _____
Signature

****By signing above parent/guardian agrees to and understands the above emergency procedures. _____
Initials

Clinician Signature: _____ Date: _____

# South Shore Behavioral Health Clinic

## THERAPEUTIC MENTORING
## Information for Parents/Guardians

- This service is a one-to-one skill-building service with your child
- This service was referred by your child's ICC, In Home Therapist, or Outpatient Therapist.
- The Therapeutic Mentor will meet with your child at home or out in the community. Any community activity will be pre-planned and must focus on skills identified in your child's treatment goals. Your child must currently display safe and stable behavior in order for any community activity to occur.
- Here are some examples of what the Therapeutic Mentor can do while meeting with your child:
    - Communication skills
    - Social skills
    - Skills around managing hygiene
    - Peer relationship management skills
    - Problem-solving skills
    - Conflict resolution skills
    - Behavior management skills
- Transportation for community activities: If this is deemed appropriate by the Therapeutic Mentor, the goal is to engage your child in community activities without any financial cost. If there is an activity that does require money, as the parent/guardian, you are responsible to cover the cost for your child. You will also be aware of the start and end times of the activity, where the activity will occur, and will have the cell phone number of the Therapeutic Mentor, only to be used in case of emergency <u>while your child is on a visit</u> with his/her Therapeutic Mentor.

# Therapeutic Mentoring Transportation Consent

Youth's Name:_____ Client #:_____

TM:_____ DOB:_____

As the parent/guardian for_____, I give consent for the Therapeutic Mentor at South Shore Behavioral Health Clinic to transport my child for the purposes of engaging in community activities. I acknowledge that it is my responsibility to provide and secure any needed child passenger restraints.

I acknowledge that I will be made aware of the planned activities and I will be notified of the specific start and end times of the activities. I acknowledge that I do have the cell phone number of the Therapeutic Mentor that can be utilized for contact purposes only during these specific activity times; all other times I will uses the Therapeutic Mentor's office number.

I agree to be available for calls from the Therapeutic Mentor during the activity times and will be home to accept my child at the end of the session time. If you have any concerns regarding your child's car safety please explain on back of this page.

| | |
|---|---|
| **Child's Information**<br>_____ Child's Age<br>_____ Child's Height<br>_____ Child's Weight | **Infant Carrier Seats -Rear Facing:**<br>❑ Newborn to approximately 6 months of age<br>❑ Weigh under 20 lbs.<br>❑ Height under 26 inches |
| **Rear Facing Convertible Seats:**<br>❑ 6 months to 1+ years of age<br>❑ Weigh under 30 lbs.<br>❑ Top of head at least 1 inch below top of seat | **Forward Facing Seat:**<br>❑ Over 1 year of age<br>❑ Weigh under 40 lbs. (but over 20lbs)<br>❑ Top of shoulders are below top harness slots on seat |
| **Booster Seat-with Adult Lap and Shoulder Seat Belt:**<br>❑ Approximately 4 to 8 years of age<br>❑ Weigh over 40 lbs.<br>❑ Height under 4'9" | **Adult Lap and Shoulder Belt:**<br>❑ Approximately 8+ years of age<br>❑ Approximately 80+ lbs.<br>❑ Height is 4'9" or taller |

Parent/Guardian Name (Printed):_____

Parent/Guardian Signature:_____Date:_____

TM Signature:_____Date:_____

# South Shore Behavioral Health Clinic

200 Cordwainer Drive, Suite 200 Norwell MA 02061 781-878-8340

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is posted in our waiting room. A copy of this document is also available from our front office staff. Please contact our Privacy Officer about any questions or problems you may have.

We will use information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

*For Treatment*
We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, vocational testing, treatment planning, or measuring the benefits of our services.

We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, they can share some of your PHI with us so that the services you receive will be able to work together. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

*For Payment*
We may use your information to bill you, your insurance, or others so we can be paid for the treatments we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we have met, your progress, and other similar things.

*Your Health Care Operations*
There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

*Other Uses in Healthcare*
Appointment Reminders. We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatment or alternatives that may be of help to you.

Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

# South Shore Behavioral Health Clinic

DIAGNOSTIC INTAKE

Client Name:_____ DOB:_____

Clinician:_____ Date Completed: _____

1. Place of Service: ❑Clinic ❑Client Home ❑Nursing Home
❑School ❑ Day Program _____❑Other: *(specify)*

2. Reason Client is Seeking Mental Health Services (presenting problem): _____

_____

_____

3. Agencies With Whom Client is Involved: **(Check all that apply)**

❑ DMH ❑ DCF ❑ DYS ❑ DMR ❑ Other *(including probation /court ordered)*_____

❑ None ❑ Other Agencies _____

4. History

*A.* Symptom History *(current symptoms / age of onset/ effect on functioning)*

_____

_____

_____

B. Client's Current Life Situation or Marital Status:

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Partner

Current Residence (describe):_____

Members of Current Household: _____

Current Daily Activity Pattern:

Employed ❑ Student ❑ Unemployed ❑ Retired ❑ Day Program Describe:_____

Financial Status: ❑ Comfortable ❑ Stable ❑ No Steady Income

❑Receives Assistance:_____

C. Recent Life Stressors of Life Changes: _____

_____

D. Developmental / Educational History:

Early Developmental Milestones: _____

Highest Grade Completed: _____

Describe Client's School Functioning:_____

*E.* Significant Family Relationships *(include family of origin):* _____

_____

_____

# South Shore Behavioral Health Clinic

DIAGNOSTIC TREATMENT PLAN

Client Name:_____DOB:_____:

Clinician:_____Date Completed:_____

F. Childhood Losses /Trauma

❑ Parental Divorce ❑Death of Parent ❑Death of Sibling
❑ Parental Substance Abuse ❑Abuse /Neglect ❑Foster Care/Adoption
❑Domestic Violence Victim ❑Domestic Violence Witness ❑ Other

**Describe the impact of the above**

_____

G. Legal Status (history or current involvement in the legal system):

_____

H. Military Status: ❑None ❑Active ❑Veteran

5. History of Mental Health Care:

❑Outpatient ❑ Inpatient

Describe:

_____

*Medication History:* _____

*Prescribing Physician:*_____

*Family History of Mental Illness:* _____

_____

6. Relevant Medical History:

Primary Care Physician: _____

Current Conditions/Allergies: _____

Current Medications: _____

7. Alcohol / Substance Use History **❑ Yes / ❑ No / ❑ None Reported (Please Specify Below)**

| Substance | First use | Peak usage Amt | Current Use | Last Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

8. Mental Status:

*A. Communication Barriers:*

❑ *No* ❑*Yes*

*B. Behavior, Attitudes, and Activities:*

General Behavior ❑ Unremarkable ❑ Other _____
Dress / Appearance ❑ Unremarkable ❑ Other _____
Voice ❑ Unremarkable ❑ Other _____
Motor Activity ❑Unremarkable ❑Other _____
Orientation ❑ Unremarkable ❑ Other _____

*C. Physiological Functioning and Initiative:*

| | | |
|---|---|---|
| Disturbance of Sleep | ❑Absent | ❑ Present_____ |
| Eating Disturbance | ❑Absent | ❑ Present_____ |
| Sexual Disturbance | ❑ Absent | ❑ Present_____ |
| Muscle Tension | ❑Absent | ❑Present _____ |
| Sweating | ❑ Absent | ❑Present _____ |
| Quick to Startle | ❑ Absent | ❑ Present_____ |

*D. Mental Activity, Speech and Thought:*

| | | |
|---|---|---|
| Form of Speech | ❑ Absent | ❑ Present_____ |
| General Content | ❑ Absent | ❑ Present_____ |
| Hypochondriasis | ❑ Absent | ❑ Present_____ |
| Phobias | ❑ Absent | ❑ Present _____ |
| Delusions | ❑ Absent | ❑ Present_____ |
| Loose Associations | ❑ Absent | ❑ Present _____ |
| Thought Insertion | ❑ Absent | ❑ Present _____ |
| Intrusive Thoughts | ❑ Absent | ❑ Present _____ |
| Obsessions | ❑ Absent | ❑ Present _____ |
| Flight of Ideas | ❑ Absent | ❑ Present _____ |

*E. Disorders of Perception:*

| | | |
|---|---|---|
| Depersonalization | ❑ Absent | ❑ Present _____ |
| Derealization | ❑Absent | ❑ Present _____ |
| Illusions | ❑ Absent | ❑ Present _____ |
| Visual Hallucinations | ❑ Absent | ❑ Present _____ |
| Auditory Hallucinations | ❑Absent | ❑ Present _____ |

*F. Mood /Affect:*

Predominant Mood: _____

Predominant Affect: _____

*G. Cognitive functioning (estimate):*

❑ Below average ❑ Average ❑ Above Average

9. . Mood and Emotional Symptoms:

| | | |
|---|---|---|
| ❑Depressed | ❑Diminished Energy | ❑ Diminished Concentration |
| ❑Anxious | ❑Guilt / Self-blame | ❑ Diminished Interest / Pleasure |
| ❑Hopelessness | ❑Helplessness | ❑ Persistent / Unrealistic Worries |
| ❑Suicidal Ideation | ❑Homicidal Ideation | |

10. Risk Assessment:

*Suicidality:*

❑None present ❑ Ideation ❑Plan ❑ Intent to Act ❑Available Means to Act ❑Previous Attempts

*Level of Risk:* ❑Low ❑ Moderate ❑ High ❑ ECP attached

NOTE: Moderate to High risk requires attached Emergency / Crisis Plan (ECP)

*Describe in Detail:*

*Homicidality:*

❑ None Present ❑ History of Assaultive Behavior ❑ Access to Weapons

❑ Plan to Use Weapons ❑ Intended Victim Identified *(Please not duty to warn victim and police)*

*Level of Risk:* ❑ Low ❑ Moderate ❑ High ❑ ECP attached

NOTE: Moderate to High risk requires attached Emergency / Crisis Plan (ECP)

*Describe in Detail:*

# South Shore Behavioral Health Clinic

DIAGNOSTIC TREATMENT PLAN

Client Name:_____ DOB:_____

Clinician:_____ Date Completed:_____

9. Client Strengths/Protective Factors: ❑Academic ❑Behavioral ❑Cognitive ❑Communicative ❑Community ❑Family ❑Financial ❑Hopeful for Recovery ❑Motivated for Treatment ❑Physical ❑Relationships ❑Social ❑Spiritual ❑Other: _____

10. Client Leisure/Meaningful Activities:

_____

_____

11. Client Social Supports:

_____

_____

12. Client Religious/Spiritual Beliefs and Cultural Identification:

_____

_____

13. Client's Identified Goals:

_____

_____

14. Language Ability

_____

_____