



Welcome to Summit Counseling Services,

Enclosed is the intake paperwork needed to establish care with Summit Counseling. Please complete the packet entirely with required signatures. Estimated completion time is 30 minutes to complete. The Grievance Form at the end of the packet is for your use in case you have a concern with Summit Counseling Services and is not necessary to complete in order to establish services.

For best results please utilize Adobe Fill and Sign to complete the PDF Fillable intake paperwork. You may also print the paperwork and complete by hand, submitting electronically by email to [awagner@summitcounselinginc.org](mailto:awagner@summitcounselinginc.org) or fax to 701-713-3299.

Thank you! If you experience difficulties, please contact us at 701-334-6242 for assistance.

Jennie Cornell, MSW, LCSW, CDBT  
Clinical Director

Summit Counseling Services



# Adult Bio-Psychosocial Assessment

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Physical Address: _____ _____ _____	Mailing Address: (If Different) _____ _____ _____
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Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

What brings you in today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you been experiencing this problem? ☐ 1-6 months ☐ 1-5 years ☐ 5+ years

Please rate the intensity of his problem (1 being mild – 5 being severe)

☐ 1 Mild ☐ 2 Moderately Mild ☐ 3 Moderate ☐ 4 Moderately Severe ☐ 5 Severe

How does this problem affect you on a day to day basis? Does it affect your relationship? Your work? School?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced any of the following symptoms in the past 30 days?

<input type="checkbox"/> Acting out	<input type="checkbox"/> Anergia (No Energy)	<input type="checkbox"/> Anger	<input type="checkbox"/> Anhedonia (No Fun/Joy)
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Concentration Difficulties	<input type="checkbox"/> Crying Spells	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Feeling Worthless	<input type="checkbox"/> Guilt	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Increased Substance Use
<input type="checkbox"/> Increased Worrying	<input type="checkbox"/> Irritability	<input type="checkbox"/> Isolation	<input type="checkbox"/> Low/No Sex Drive
<input type="checkbox"/> Sadness	<input type="checkbox"/> School Misconduct	<input type="checkbox"/> Sleep Difficulty	<input type="checkbox"/> Sociability Decreased
<input type="checkbox"/> Apprehensiveness	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Confusion
<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Muscular Tension	<input type="checkbox"/> Phobias	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Impending Doom	<input type="checkbox"/> Difficulty Relaxing	<input type="checkbox"/> Constant Worrying	<input type="checkbox"/> Embarrassment
<input type="checkbox"/> Too much energy	<input type="checkbox"/> No Need for sleep	<input type="checkbox"/> Talking too fast	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Suspiciousness	<input type="checkbox"/> Hearing things	<input type="checkbox"/> Seeing things that are not there	<input type="checkbox"/> Having special powers
<input type="checkbox"/> Believing people are watching you	<input type="checkbox"/> Feeling Nervous	<input type="checkbox"/> Fearful	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Difficulty being in crowds	<input type="checkbox"/> Easily startled	<input type="checkbox"/> Nightmares	<input type="checkbox"/> No motivation

If you have experienced anxiety or panic attacks, please indicate the symptoms you have experienced:

<input type="checkbox"/> Chest pain or discomfort	<input type="checkbox"/> Chills/Hot Flashes	<input type="checkbox"/> Choking sensations
<input type="checkbox"/> Derealization (Feeling detached)	<input type="checkbox"/> Dizziness/Lightheadedness	<input type="checkbox"/> Fear of Dying
<input type="checkbox"/> Fear of losing control	<input type="checkbox"/> Increased heart rate	<input type="checkbox"/> Nausea/Abdominal Pain
<input type="checkbox"/> Paresthesia (Tingling/Numbness)	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Sweating
<input type="checkbox"/> Trembling or Shaking	<input type="checkbox"/> Other: _____	
How often do you feel these symptoms or have these attacks? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		

Have you received mental health services (seen a Therapist – Psychologist – Psychiatrist) in the past?

☐ No ☐ Yes. If so, when \_\_\_\_\_ Who? \_\_\_\_\_

What did you see them for? \_\_\_\_\_

List prior Mental Health Diagnoses: \_\_\_\_\_

Are there mental health concerns in your family? ☐ No ☐ Yes If so, what and with whom? \_\_\_\_\_

Have you ever been hospitalized for mental health concerns? ☐ No ☐ Yes If so, where and why? \_\_\_\_\_

Are you on any medications for mental health concerns? ☐ No ☐ Yes If so, please list name and dosages \_\_\_\_\_

Have you ever experienced verbal, emotional, physical or sexual abuse? ☐ No ☐ Yes If so, please explain \_\_\_\_\_

## HEALTH:

Please list any current and chronic health conditions: \_\_\_\_\_

Have you experienced Head trauma? ☐ No ☐ Yes Explain: \_\_\_\_\_

Please list any medications for health conditions: \_\_\_\_\_

Who are your health care providers? \_\_\_\_\_

Are you pregnant? ☐ No ☐ Yes

Are you at risk for HIV/AIDS/Sexually Transmitted Diseases? ☐ No ☐ Yes

Please list any allergies \_\_\_\_\_

### SUBSTANCE USE:

Do you currently use tobacco products (snuff, cigarettes)? If no, please skip to the next section

What form? ☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Chewing Tobacco ☐ Snus

How long have you used tobacco? \_\_\_\_\_ How much do you use? \_\_\_\_\_

Would you like information about how to quit using tobacco products? ☐ No ☐ Yes

Would you or someone you know say you are having a problem with drugs, alcohol, gambling, overspending or sexual addiction? ☐ No ☐ Yes. If yes, which problem? \_\_\_\_\_

Have you ever tried quitting? ☐ No ☐ Yes

Would you like information about any of these issues? ☐ No ☐ Yes

### SOCIAL:

Do you have **friends**? ☐ No ☐ Yes How is your relationship with friends? \_\_\_\_\_

How many **siblings** do you have? \_\_\_\_\_ How would you describe your relationship with your siblings? \_\_\_\_\_

How is your relationship with your parents? \_\_\_\_\_

**Relationship status:** ☐ Single ☐ Married ☐ Living as Married ☐ Divorced ☐ Other: \_\_\_\_\_

How would you describe this relationship? \_\_\_\_\_

Do you have children? What are their ages? How is your relationship with them? \_\_\_\_\_

Are you experiencing any difficulties at work or school? If so, please describe \_\_\_\_\_

What is your highest level of **education**? \_\_\_\_\_

Have you ever been diagnosed with a learning disability? If so, what? \_\_\_\_\_

Please describe your **work history** (what is your relationships with your supervisor and other co-workers? Do you like your job? How long have you been there? What did you do prior to this job?)

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Have you ever been charged with a crime? ☐ No ☐ Yes (If yes, please identify what charges)

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Have you ever been in the **military** ☐ No ☐ Yes, Type of discharge? \_\_\_\_\_

Do your finances contribute to the reason you are here today? Are your basic needs met?

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Please share anything else you would like the therapist to know

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## Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

**Please circle your answers.**

<b>PHQ-9</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
<b>Add the score for each column</b>				

**Total Score (add your column scores):** \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all**

**Somewhat difficult**

**Very Difficult**

**Extremely Difficult**

**Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.**

<b>GAD-7</b>	<b>Not at all sure</b>	<b>Several days</b>	<b>Over half the days</b>	<b>Nearly every day</b>
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
<b>Add the score for each column</b>				

**Total Score (add your column scores):** \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all**

**Somewhat difficult**

**Very Difficult**

**Extremely Difficult**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

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## Client Rights/Informed Consent

CLIENT RIGHTS: As a consumer of services of Summit Counseling Services, you have the right:

- 1) To be treated with respect and dignity in a culturally sensitive manner
- 2) To be informed of eligibility criteria for the service in which you participate
- 3) To receive assistance with any communication barriers which make it difficult for you to receive services
- 4) To be free from discrimination while receiving services
- 5) To have access to your file according to federal/state/agency regulations and standards
- 6) To terminate services at any time
- 7) To be free from exploitation for the benefit or advantage of a staff member
- 8) To report complaints/grievances using the agency guidelines provided to you
- 9) To confidentiality as defined by policy and law. Summit Counseling Services maintains a strict policy on confidentiality of information (verbal, written, or electronic form). All information you share, or which we become aware of through our work with you will remain confidential. (According to state and federal statutes, Addiction records 42CFR Part 2) There are some circumstances in which this policy becomes void and we are required by law to release information:
  - If we become aware that you may be a danger to yourself or others
  - If we become aware of or suspect child abuse or neglect or vulnerable adult abuse and/or neglect
  - If we become aware of a medical emergency
  - If we are court ordered to testify or to submit our records to the court
  - If we become aware you have intent to commit a crime
  - According to State and National Ethic Policies if you are a third-party person sitting in on another client's session(s), you do not have the expectation of confidentiality. Confidentiality is afforded to the identified client only.
  - If a request is made by Homeland Security through the Patriot Act for information, your confidentiality is not protected.

SUMMIT'S EXPECTATIONS: As Summit Counseling Services provides services, it is expected:

- 1) That clients will be present and on time for appointments.
- 2) Rescheduling or cancellations must be 24 hours in advance of appointment or appointment will be automatically billed to client at full billing rate of session.
- 3) That clients will participate in service planning
- 4) That clients will not exhibit abusive threatening, or assaultive behavior
- 5) The clients will not be under the influence of chemicals during services
- 6) That clients will respect and protect the privacy of other client's information of which they may become aware

**Summit Counseling Services reserves the right to deny services based on the above criteria.**

INFORMED CONSENT: Informed consent is a process throughout the service relationship where discussion occurs between client and service providers. Clients have opportunities to ask questions in order to understand options available to them, consequences of different choices, and how the organization can help them achieve their choices. The following are components of informed consent:

- 1) Fees and payments
- 2) Staff qualifications, training, experience, credentials and Professional Statements, if applicable;
- 3) The types of services to be provided, expected length of services, results of any tests/assessments;
- 4) Risks, benefits and alternatives to service;
- 5) Range of services available through Summit Counseling Services;
- 6) Your active participation in your service plan with freedom to revise goals throughout service;
- 7) Possible outcomes of service;
- 8) Procedure for case closure

Summit Counseling Services is a training agency and participates with multiple colleges to assist in the training of their students. From time to time, students are required to share minimal information with their supervisors in order to benefit their educational opportunities and training.

Summit Counseling Services Operates as a Community Behavioral Health Clinic. We are not trained as experts. It is for this reason we will not write letters of recommendation, testify in child custody disputes, divorce cases, or other civil litigation.

1 HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTAND THE ABOVE INFORMATION.

Client Signature\_\_\_\_\_Date\_\_\_\_\_

Parent/Guardian signature\_\_\_\_\_Date\_\_\_\_\_

Witness/Staff presenting information\_\_\_\_\_Date\_\_\_\_\_

Client was offered a copy of this document





## Authorization for Release of Information to Insurance Company

I authorize Summit Counseling Services and all business partners to release billing information which may include client name, date, type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/ies for the purpose of collecting insurance benefits or for authorization of additional sessions for:

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

- I understand that I have the right to inspect the information released through this authorization and such an inspection will occur in a meeting with Brenda Owen.
- I understand that I may revoke this authorization by providing a written revocation.
- I also understand any information released prior to the revocation may be used for the purpose(s) listed above.
- A photocopy of this authorization shall have the same force as the original.
- This release shall be valid for one year following your last appointment, unless otherwise restricted.
- **NO SHOW OR LATE CANCELLATION FEES WILL BE THE SOLE RESPONSIBILITY OF THE CLIENT**

Insurance Carrier— Name and Date of Birth	
Insurance Company-	
Insurance company address:	
Insurance Company Phone Number:	
Policy Number:	
Group Number if applicable	
Date coverage started if listed on card	
Co pay listed on card	

Although your insurance MAY cover all your fees, ultimately it is your responsibility to cover all your costs. Some plans require preauthorization before your first visit. It is YOUR responsibility to obtain this authorization. Mental health benefits may differ from your medical benefits, so it is essential that you have researched your mental health benefits prior to your visit. If you have not done this prior to your visit, and/or your treatment is not a payable benefit, you will be responsible for the full cash payment at the time of service. Further, if your insurance carrier determines that the services received are not medically necessary, you will be responsible for full payment of your accrued fees.

Insurance Carrier: \_\_\_\_\_

Carrier's Relationship to Client: \_\_\_\_\_

Carrier's Place of Employment: \_\_\_\_\_

Carrier's Date of Birth: \_\_\_\_\_

Carrier's Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## **Technology Waiver**

Communication by Email, Text Message, or Video Conferencing

It may become beneficial during your treatment to communicate using technology. At the present time SUMMIT COUNSELING SERVICE Inc. utilizes Microsoft Teams software and has been assured that their conferencing systems meet the criteria to maintain confidentiality according to federal statute 42 CFR, Part 2 and HIPPA confidentiality requirements. As a policy practice, we work hard to ensure that all communication with patients and/or families via technology is secure.

### **CONSENT FOR TRANSMISSION OF PREOTECTED HEALTH/ADDICTION INFORMATION BY SECURE/NON-SECURE MEANS**

I consent to allow you to use secure/non-secure technology to transmit to me protected health information:

- Information related to scheduling of meetings and appointments
- Information related to referral sources
- Information related to evaluation, assessment, and programming

I have been informed of the risk, including but not limited to my confidentiality in treatment, of transmitting my protected health/addiction information by secure/unsecured means. I understand that I am not required to sign this agreement in order to receive treatment, however it may limit my treatment options in regard to accessibility. I also understand that I may terminate this consent at any time.

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Signature of Client

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Date

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Witness

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Date



PHONE 701-334-6242

FAX: 701-713-3299

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**Grievance Process:** If at any time a client has an issue or concern with a staff member infringing on their rights, they are encouraged to first to attempt to address this issue with the person with whom the infringement allegedly took place with. If the client is unable to get satisfaction, clients are encouraged to fill out the grievance form provided in all offices utilized by Summit Counseling Services or from any staff person that provides services for Summit Counseling Services and submit it to the owner/operator of Summit Counseling Services. Clients will be appraised of their right to file a grievance with the Boards of Addiction Counseling Examiners North Dakota Board of Counseling Examiners and North Dakota Board of Social Work Examiners. They will be provided with the telephone numbers, web site information and/or address of the appropriate board/or boards.

- Summit Counseling Services shall protect the fundamental human, civil, constitutional and statutory rights of each client
  - As appropriate Summit Counseling Services shall inform the client, the client's family or the client's leg I guardian of their status as authorized by the client who is 14 years or older. Summit Counseling Services is only licensed for adult addiction programming and does not provide adolescent addiction programming at this time.
  - Summit Counseling Services shall evaluate to ensure no restrictions were placed on the rights of individual clients and shall document in the clinical records the clinical rationale for, such restrictions.
  - Grievances must be investigated and addressed by the owner/operator of the agency within 20 working days of receipt of grievance. Should the client believe that the grievance was not addressed appropriately they will be referred to the appropriate State Licensing Agency Board for resolution.
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3111 E. Broadway Ave, Bismarck ND 58501

26 1<sup>st</sup> St E, Dickinson ND, 58601

(Administrative Office) 1500 14<sup>th</sup> St W Suite 290, Williston ND 58801



## GRIEVANCE FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Services: \_\_\_\_\_

Description of the grievance. What are your concerns?

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Administrative Use Only

Date reviewed and signature of SUMMIT COUNSELING SUPERVISOR:

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Follow up comments: \_\_\_\_\_

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Correction Procedure/Results of inquiry: \_\_\_\_\_

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Summit Counseling Supervisor Signature:

\_\_\_\_\_ Date: \_\_\_\_\_