SUMMIT
COUNSELING SERVICES

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 MyPaperwork@summitcounselinginc.org or fax to 701-713-3299.

Thank you! If you experience difficulties, please contact us at 701-751-0299 for assistance.

Jennie Cornell, MSW, LCSW, CDBT
Clincal Director

Summit Counseling Services

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Today's Date: _____

Name:	Date of Birth:
SSN:	Phone:
Email:	
Physical Address: _____ _____ _____	Mailing Address (if different) _____ _____ _____

Name of Person Responsible for Payment (Check this box if same as person listed above ☐)

If different please list below:

Name:	Their Phone:
Their DOB:	
Their Address: _____ _____ _____	

Couples Counseling Initial Intake Form

Please note that while you will be asked to talk about your answers in session, your partner will not be shown this form.

Today's Date: _____ Name: _____

Email: _____ Phone: _____

Ok to Email? ☐ Yes ☐ No Ok to leave a message? ☐ Yes ☐ No

Relationship Status:

☐Married	☐Living Together	☐Divorced
☐Separated	☐Living Apart	☐Dating

What do you hope to accomplish through counseling? _____

_____

_____

_____

What have you already done to deal with the difficulties? _____

_____

_____

_____

What are your biggest strengths as a couple? _____

_____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship. (1- extremely unhappy to 10 extremely happy)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does: _____

_____

_____

Have you received prior couples counseling related to any of the above problems? ☐ Yes ☐ No

If Yes, with whom: _____

Where: _____ Length of treatment _____

Outcome: _____

_____

Has either partner received individual counseling before? ☐ Yes ☐ No
If so, give a brief summary of concerns you addressed: _____
_____
_____
_____

Do either you or your partner drink alcohol or take drugs to intoxication? ☐ Yes ☐ No
If Yes for either, who, how often, and what drugs or alcohol? _____
_____

Do you ever wish your partner would cut back on his/her drinking or drug use? ☐ Yes ☐ No ☐ N/A

Have either you or your partner struck, physically restrained, used violence against or injured the other person?
☐ Yes ☐ No If yes, who, how often and what happened? _____
_____
_____
_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?
☐ Yes ☐ No If yes, Who? ☐ Me ☐ Partner ☐ Both of Us

If married, have either you or your partner consulted with a lawyer about divorce?
☐ Yes ☐ No If yes, Who? ☐ Me ☐ Partner ☐ Both of Us

Do you perceive that either you or your partner has withdrawn from the relationship?
☐ Yes ☐ No If yes, Who? ☐ Me ☐ Partner ☐ Both of Us

How enjoyable is your sexual relationship? (Circle one)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relationship? (Circle one)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
(no stress) (high stress)

Rank the order of the top three concerns you have in your relationship with your partner in order of the most problematic:

1. _____
2. _____
3. _____

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
   (Grievance forms are available on our website, or upon request at any Summit location reception desk)
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:

l) 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

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. **The parties acknowledge and agree that this typed electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.**

_____ _____

Signature of Client Date

_____ _____

Witness Date

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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.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
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
Add the score for each column				

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.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
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
Add the score for each column				

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**

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PHONE 701-751-0299 FAX: 701-713-3299

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.

3111 E. Broadway Ave, Bismarck ND 58501

26 1st St E, Dickinson ND, 58601

(Administrative Office) 1500 14th St W Suite 290, Williston ND 58801

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CONSENT TO WORK WITH STUDENTS

You are being asked to allow a student who is completing coursework for their degree program. This student is completing their coursework and training requirements for national standards. This student is being supervised by both their academic supervisor and a supervisor from this agency. In keeping with the code of ethics, all records and contacts made are considered confidential professional information. This student may request permission to record counseling sessions with audio or videotaping equipment or otherwise use these recordings to develop transcripts of counseling sessions. These tapes and transcriptions are intended to enhance their professional training and improve the services you receive. If you agree, these tapes and transcripts will be considered confidential professional information and will be protected by the student and supervisors of the student in keeping with the code of ethics. The only time this confidentiality may be breached is at our request or when required by law. You may terminate this agreement at any time.

_____ _____

Client Date

_____ _____

Witness Date