



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 701-334-6242 for assistance.

Jennie Cornell, MSW, LCSW, CDBT
Clinical Director

Summit Counseling Services



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: _____ _____ _____	



Today's Date: _____ Name: _____

Email: _____ Phone: _____

Ok to leave a message? ☐ Yes ☐ No

<input type="checkbox"/> Married	<input type="checkbox"/> Living Together	<input type="checkbox"/> Divorced
<input type="checkbox"/> Separated	<input type="checkbox"/> Living Apart	<input type="checkbox"/> 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)

[illegible]

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. _____



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Email: _____ Phone: _____

Ok to leave a message? ☐ Yes ☐ No

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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
- 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.

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.

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 PROTECTED 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



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. **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.**

Insurance Carrier: _____

Carrier's Relationship to Client: _____

Carrier's Place of Employment: _____

Carrier's Date of Birth: _____

Carrier's Phone: _____

Signature: _____



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

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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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PHONE 701-334-6242

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 legal 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



GRIEVANCE FORM

Name: _____ Date: _____

Reason for Services: _____

Description of the grievance. What are your concerns?

Signature: _____ Date: _____

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.

Administrative Use Only

Date reviewed and signature of SUMMIT COUNSELING SUPERVISOR:

Follow up comments: _____

Correction Procedure/Results of inquiry: _____

Summit Counseling Supervisor Signature:

_____ Date: _____