



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:	



Child/Adolescent Bio-Psychosocial Assessment

(for parent and/or child/adolescent to complete)

Today's Date: _____ Child's Name: _____

Child's Age _____ Date of Birth: _____ School Child Attends: _____

School Release Signed? ☐ Yes ☐ No Current Grade in School _____

Mother/Step Parent Name & Address:	Father/Step parent Name & Address:
Phone #:	Phone #:
Primary Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes Name, Address & Phone:	

Custody Arrangements: ☐ Yes ☐ No If Yes, please indicate current arrangement: (Joint, Which parent has primary custody, any stipulations with custody agreement, etc) Please also provide a copy of the court order if applicable:

Top 3 Concerns/Reasons for Seeking Services: (Please note when these concerns first started for your child , ex: age 3 after attending a friend's birthday party)

1. _____

2. _____

3. _____

Who resides in the home? (Please list names/ages/relationship to the child). Any Pets? Parents/Guardians- What is your occupation? _____

How does everyone get along? _____

Here is a list of **common symptoms** – please indicate those that concern you about your child.

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Depressed/Sad | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Loss of Interests | <input type="checkbox"/> Self-Injurious Behaviors |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Defiant | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Aggression | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Over Sexualized Behaviors |
| <input type="checkbox"/> Poor Self control | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Poor Focus | <input type="checkbox"/> Destruction of Property |
| <input type="checkbox"/> Excessive Fears | <input type="checkbox"/> Worry | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fecal Soiling | <input type="checkbox"/> Involuntary Urination |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Delusions | <input type="checkbox"/> Dissociations | <input type="checkbox"/> Regressive Traits | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Immaturity | <input type="checkbox"/> Academic Issues | <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Physical Complaints | |
| <input type="checkbox"/> Other: _____ | | | | |

Has your child ever had counseling before? ☐ Yes ☐ No If Yes, Where and When? _____

Any psychiatric hospitalizations? ☐ Yes ☐ No If Yes please note where and the dates of service: _____

Any involvement in the legal system? ☐ Yes ☐ No On probation? ☐ Yes ☐ No If yes, please explain below: _____

Family Dynamics: Family History of Mental Health Concerns:

Family History of Drug/Alcohol Concerns: _____

Parenting Who typically disciplines the child? _____

How does that discipline typically look in your household? (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Remove Privileges | <input type="checkbox"/> Add Chores | <input type="checkbox"/> Yell/Scream/Shout | <input type="checkbox"/> Lecture |
| <input type="checkbox"/> Time Out | <input type="checkbox"/> Ignore | <input type="checkbox"/> Discuss Situation with Child | <input type="checkbox"/> Spank with Hand |
| <input type="checkbox"/> Spank with Object | <input type="checkbox"/> Send to Room (alone) | <input type="checkbox"/> Grounding | |
| <input type="checkbox"/> Other: _____ | | | |

Are you consistent with your discipline? ☐ Yes ☐ No Any Difficulties with providing discipline? ☐ Yes ☐ No If yes, please explain why it is difficult to discipline: _____

How does your child typically respond when disciplined? _____

Risk Assessment:

Has your child ever had thoughts of harming his/herself? ☐ Yes ☐ No If Yes- please answer the following:

Has your child had a plan to do so? ☐ Yes ☐ No

Has your child ever attempted to harm his/herself? ☐ Yes ☐ No

Has your child attempted to harm others? ☐ Yes ☐ No If yes how so? _____

Has your child ever intentionally harmed an animal/pet? ☐ Yes ☐ No If so what happened? _____

Have you called the Crisis Line or any Crisis Interventions for your child? ☐ Yes ☐ No If Yes, please explain: _____

History of Substance Use/Abuse

Has your child used/are using the following (add other info as needed):

- | | | | |
|---------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> OTC | <input type="checkbox"/> Inhalants | <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Rx Med Abuse | <input type="checkbox"/> Heroin/opiates | <input type="checkbox"/> Synthetic/Club Drugs |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Meth |
| <input type="checkbox"/> Other: _____ | | | |

Received any drug/alcohol assessments or treatment? ☐ Yes ☐ No

If yes Where? _____ When? _____

Medical Information

Is your child currently on any medications? ☐ Yes ☐ No If yes please list below and who prescribes:

Please list any current medical issues, allergies, history of medical hospitalizations for medical issues or any histories of head injuries: _____

How was the pregnancy/delivery with the child? Any complications? Time spent in the NICU? Ongoing medical issues as a result? _____

Developmental Milestones: (Please note if your child was on time, delayed or early)

Speaking: ☐ on time ☐ early ☐ delayed (at what age?) _____

Walking: ☐ on time ☐ early ☐ delayed (at what age?) _____

Potty Trained: ☐ on time ☐ early ☐ delayed (at what age?) _____

Females- menstruating? ☐ Yes ☐ No Age at first period _____

Any ongoing issues with bathroom/bedwetting? ☐ Yes ☐ No If yes please describe below: _____

Trauma History

Below is a list of common stressors for children. Please indicate if your child has experienced any of the following and feel free to elaborate:

- | | | |
|---|---|--|
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Emotional Abuse or Neglect | <input type="checkbox"/> Witness to Domestic Violence | <input type="checkbox"/> Sudden Loss of Family Member or Pet |
| <input type="checkbox"/> Frequent Moving/Homelessness | <input type="checkbox"/> Abandonment | <input type="checkbox"/> Incarcerated Family Member |
| <input type="checkbox"/> Alcohol/Drug Abuser in Household | <input type="checkbox"/> Grief/Bereavement | <input type="checkbox"/> Witness to Community Violence |
| <input type="checkbox"/> Household member with Serious/Chronic Mental Health Issues | <input type="checkbox"/> Life Threatening Experience | |
| <input type="checkbox"/> Other: _____ | | |

School History

Please note any issues experienced in the school setting (examples include: grades changing drastically, behavioral concerns at school, social difficulty, bullying, etc)

Is your child involved in any extracurricular activities either inside of school, church or outside of the school setting? (sports, music, clubs, youth groups, employed, etc.)

What technology does your child have current access to? Please indicate those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Smart Phone | <input type="checkbox"/> Computer w/Internet | <input type="checkbox"/> IPAD/Tablet w/internet | <input type="checkbox"/> Facebook Account |
| <input type="checkbox"/> Twitter Account | <input type="checkbox"/> Instagram Account | <input type="checkbox"/> Snap Chat Account | <input type="checkbox"/> Video Game |

If video games, which ones? _____

Other: _____

How is this technology monitored in your home? _____

Do you have password access? _____ How does your child primarily communicate with their friends?

Have there been any issues with your child being bullied or bullying others online? Yes No If yes, please explain:

Any other online issues? (Communicating with strangers, etc) Yes No If yes – please describe:

Additional Supports: Please make note of any additional supports your child has in his/her life that they have regular access to (grandparents, other family members, best friends, coaches, youth advisors, etc)

Strengths Please tell us some of your child's biggest strengths. What are the best things about him/her?

What are his/her favorite things to do for fun? _____

Is there anything else you would like us to know about your child?

What Goals would you like your child to address in therapy/treatment?
1. _____

2. _____

3. _____



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

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
(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:

- 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



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



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.

Signature of Client

Date

Witness

Date



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



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: _____ Date: _____