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: _____ _____ _____	

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

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 he 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: _____

SUMMIT
COUNSELING SERVICES

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 online on Summit Counseling Services website, or 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 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

Adult Bio-Psychosocial Assessment

Today's Date: _____ Name: _____
Date of Birth: _____ Email: _____

Physical Address:	Mailing Address: (If Different)
_____	_____
_____	_____
_____	_____

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?

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

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

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

_____
_____
_____

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

_____

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?

_____
_____

Please share anything else you would like the therapist to know

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SUMMIT
COUNSELING SERVICES

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**