Adolescent Registration Form

PATIENT INFORMATION

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Gender: ☐Male ☐Female ☐Nonbinary ☐Other: _____ ☐Rather not say

Date of Birth: _____/_____/_____ **Social Security**: _____

Phone Number: (_____) _____ ☐Home ☐Cell ☐Work **Phone Number #2**: (_____) _____ ☐Home ☐Cell ☐Work

Address: _____ **Appt/Suite #**: _____ **Homeless**: ☐ No ☐Yes

City: _____ **State**: _____ **Zip Code**: _____

Sexual Orientation: ☐Straight/Heterosexual ☐Lesbian/Gay/Homosexual ☐Bisexual ☐Other: _____

Ethnicity/Race: _____ **Native American**: ☐No ☐Yes - Tribe: _____

Religion: _____ **Disability**: ☐No ☐Yes: _____

Current Grade Level: _____

Parent #1

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Guardian

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Phone Number: (_____) _____ **Email Address:** _____

Address: _____ **Appt/Suite #**: _____ **Homeless**: ☐ No ☐Yes

City: _____ **State**: _____ **Zip Code**: _____

Parent #2

☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Guardian

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Phone Number: (_____) _____ **Email Address:** _____

Address: _____ **Appt/Suite #**: _____ **Homeless**: ☐ No ☐Yes

City: _____ **State**: _____ **Zip Code**: _____

EMERGENCY CONTACT

First Name, Last Name: _____ **Relationship to Patient**: _____

Phone Number: _____ **Email**: _____

INSURANCE INFORMATION

Primary Insurance: _____

Member Name: _____

Member ID/Policy: _____

Group Number: _____

Secondary Insurance: _____

Member Name: _____

Member ID/Policy: _____

Group Number: _____

Adolescent Patient's Rights

As the patient of a program for treatment of abuse of/or dependency upon alcohol or other drugs, your rights include, but are not limited to, the following:

1. If the program receives funds from the Substance Abuse Prevention and Treatment Agency (SAPTA), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract, which would be a hardship for you or your family.

2. You have the right to be provided treatment appropriate to your needs.

3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.

4. You have the right to be informed of all program services, which may be of benefit to your treatment.

5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.

6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.

7. You have the right to be informed of our diagnosis, treatment plan and prognosis.

8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.

9. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.

10. You have the right to be informed of the program's rules for your conduct at the facility.

11. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.

12. You have the right to receive respectful and considerate care.

13. You have the right to receive continuous care: To be informed of our appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.

14. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.

15. You have the right to safe, healthful and comfortable accommodations.

16. You have the right to confidential treatment. This means that, other than exceptions defined by law, such as those in which public safety takes priority, without your explicit consent to do so the program may release no information about you, including confirmation or denial that you are a patient.

17. Waiver of any civil or other right protect by law cannot be required as a condition of program services.

18. If for any reason you have a grievance with LCWC, you are encouraged to fill out a grievance form. Any staff will have a copy for you to fill out.

ACKNOWLEDGMENT OF RECEIPT OF ADOLESCENT PATIENT'S RIGHTS

I have read, understand, and have been provided a copy of the above Patient's Rights

_____ _____

Client Name (Print) Date

_____ _____

Parent Name (Print) Date

_____ _____

Parent Signature Date

NOTICE OF PRIVACY

Effective: _____ Name: _____ Date of Birth: _____

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how tour provider may use and disclose tour PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DICLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT: Your PHI may be used and disclosed by those who are involved in your care for the purposed of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

FOR PAYMENT: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

FOR HEALTH CARE OPERATIONS: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided, we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

REQUIRED BY LAW: Under the law. Your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.
WITHOUT AUTHORIZATION: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order
- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

VERBAL PERMISSION: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Users and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider.

RIGHT OF ACCESS TO INSPECT AND COPY: In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

RIGHT TO AMEND: If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request that your provider communicate with you about medical matters in a certain wat or at a certain location.

RIGHT TO A COPY OF THIS NOTICE: You may ask your provider for a paper copy of this notice at any time

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202)619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on wats my provider may use or disclose personal health information to provide service.

_____ _____
Client Name (Print) Date

_____ _____
Client Signature Date

_____ _____
Name and Relationship of person if other than client Date

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ Date of Birth: _____ Date: _____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following a Mental Health Assessment, Evaluation, and a thorough discussion with me. (A Mental Health Assessment consists of an Initial Assessment with a therapist followed by an Evaluation with a Psych Services Provider, for a more thorough Assessment.) The goal of the Mental Health Assessment and Evaluation process is to determine the best course of treatment for me. Typically, Treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment.) I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentially can be broken under certain circumstances of danger to myself and others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentially and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concerns you may have.

By my Signature below, I voluntarily request and consent to Behavioral Health Assessments, Evaluations, Care Treatment, or Services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment form, I acknowledge that I have both read and understand the

terms and information contained herein. Ample opportunity has been offered to me to ask question and seek clarification of anything unclear to me.

ACKNOWLEDGMENT OF RECEIPT OF INORMED CONSENT FOR ASSESSMENT AND TREATMENT

_____	_____
Client Name (Print)	Date
_____	_____
Client Signature	Date
_____	_____
Name and Relationship of person if other than client	Date
_____	_____
Witness	Date

CLIENT GRIEVANCE REPORT AND PROCEDURE FORM

LEGACY COUNSELING AND WORKFORCE CONNECTIONS
6600 WEST CHARLESTON BLVD SUITE 111
LAS VEGAS, NV 89146

It is the policy of Legacy Counseling and Workforce Connections to treat all clients with fairness and professionalism and to strive for excellence in providing services to clients. Legacy Counseling and Workforce Connections' policy allows clients and their families or legal guardians to express problems or grievances related to the quality of services. If you feel you have been treated unfairly or unprofessionally, or your rights have been breached, the following procedure should be used.
The Legacy Counseling and Workforce Connections Grievance Procedure is designed to provide a means for those applying for Legacy Counseling and Workforce Connections services and clients receiving services to bring a grievance to the attention of Legacy Counseling and Workforce Connections and reach a speedy resolution. Legacy Counseling and Workforce Connections has a strict policy prohibiting retaliation against anyone who files a grievance. A grievance is any situation or condition a client thinks is unfair, unjust, or inequitable. In addition, if a client states they are being treated unfairly or unprofessionally, a grievance should be completed. Under this Client Grievance Procedure, you should submit a grievance in the following sequence; in-house as follow:

1) If you have a grievance, the concern can be discussed with a Legacy Counseling and Workforce Connections staff. If you decide to speak to a Legacy Counseling and Workforce Connections staff and an agreement cannot be reached, you should proceed to the next step of this grievance procedure.
2) You can file a grievance without discussion and proceed to the next step. Grievance forms can be found at the following:
   a) The lobby/front desk of Legacy Counseling and Workforce Connections site
   b) You can request the form from any Legacy Counseling and Workforce Connections staff
   c) Call (702)763-7443 ext. 8008 to request a form
3) If the matter has not been resolved satisfactorily, you may discuss your concerns with any supervisor without fearing reprisal.

Once notified in writing, Legacy Counseling and Workforce Connections will initiate an investigation withing three (3) business days and provide an acknowledgement to you within seven (7) business days.

Legacy Counseling and Workforce Connections will report the outcome of the complaint investigation to you within fourteen (14) business days of receiving the complaint. Suppose it has not been possible to gather the necessary information to lead to a resolution by fourteen (14) days; in that case, you will be notified and given a new date, up to thirty (30) days, by which a resolution or determination will be made
If, for any reason, you are unsatisfied with the results, you may contact Legacy Counseling and Workforce Connections. A supervisor not involved with the case will review the matter and respond to you in writing within ten (10) business days.
Level of Care will comply with all laws following the Medicaid Chapters 100 and 400 guidelines. You can also fill a grievance with:

State of Nevada Substance Abuse Prevention and Treatment Agency (SAPTA)
https://dpbh.nv.gov/Programs/ClinicalSAPTA/Home_-_SAPTA/

Division of Public and Behavioral Health (DPBH)
4150 Technology Way
Carson City, NV 89706
Phone: 775-684-4200 | Fax: 775-687-7570
Email: dpbh@health.nv.gov
Business Hours: 8 AM to 5 PM

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue
Washington, DC 20530
Hotline Number: 888-848-5306

Client Name: _____ Date: _____

Client Signature: _____

Witness: _____ Date: _____

Child and Adolescent Mental Health Intake Form

Please provide the following information and answer the questions below. **Please note:** Information you provide here is protected as confidential information.

This intake form is for individuals ages 3-17 years. It may be completed by the child, the parent and/ or both.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ **Age:** _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Oher:** _____

Name of Parent of Guardian

_____
(Last) (First) (Middle Initial)

Legay Shared Document Agreement: ___Yes ___No **Custody Concerns?** ___Yes ___No

Referred by (If any): _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
___Yes ___ No

Previous therapist/practitioner: _____

Are you currently taking any prescription medication? ___Yes ___No

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ___Yes ___No

Please list and provide dates: _____

How would you rate your current physical health? (please Circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

Please provide the following information about yourself or your child if you are a parent or guardian. This information will help us better understand the problems you are having.

Problems that you are having: (please check all that apply)

	Depression		**Parent-Child (Self)**
	Suicidal thoughts		**Parent-Child conflict (spouse)**
	Suicidal actions		**Marital/relationship problems**
	Anxiety/Fears/Worries		**Remarried family problems**
	Panic attacks		**Violence in the family**
	Anger/Temper problems		**Communication problems**
	Alcohol/other drug abuse (self)		**Verbal/Emotional abuse**
	Alcohol/other drug abuse (family)		**Sexual problems**
	Job/School problems		**Sexual abuse (past or current)**
	Financial problems		**Low self-esteem**
	Legal problems		**Compulsive gambling**
	Death of a loved one		**Eating disorder**
	Major losses/difficult changes		**Sleep problems**
	Change in appetite		**Moody or crying more than usual**
	Difficulties in concentrating		**Feeling guilty, worthless, or hopeless**
	Fatigue/low energy		**Problems remembering things**
	Hyper/ too much energy		**Withdrawing from others**
	Loss of interest in things		**Disturbing thoughts I can't stop**
	Repeated actions I can't stop		**People are out to get me**

Other (please specify):

_____

Developmental History

Complications prior to birth? ___Yes ___No **Complications at birth?** ___Yes ___No

All developmental milestones met? ___Yes ___No

Any significant changes in life such as: (Please circle)

Frequent moves Changes in Caregivers Death of friend/relative

Witness to violence History of Abuse/Neglect Other

Involved in extracurricular activities (sports, youth groups, or clubs)? ___Yes ___No

What do you like to do for fun? _____

Is spirituality a part of your life? ___Yes ___No

Background/Family & Relationships Information

Where were you born? How long have you lived in Nevada?

_____

What is your mother's name and age? How is your relationship with your mother?

_____

What is your father's name and age? How is your relationship with your father?

_____

Who lives in your home with you?

_____

Do you have visits with another parent? ___Yes ___No

Describe your relationship with family:

_____

Are you dating? ___Yes ___No **Are you currently in a relationship?** ___Yes ___No

Describe your relationship with friends:

_____

Do you feel supported by your friends and family? ___Yes ___No ___Sometimes

Education

School/Day Care Name:

_____

Current Grade: _____ **IEP or 504 Plan?** ___Yes ___No

What significant life changes or stressful events have you experienced recently:

_____

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

What would you like to accomplish out of your time in therapy?

_____

Center for Epidemiology Studies Depression Scale for Children (CES-DC)

Instructions

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past* week.

DURING THE PAST WEEK	Not at all	A Little	Some	A Lot
1. I was bothered by things that usually do not bother me.	O	O	O	O
2. I did not feel like eating. I was not very hunger.	O	O	O	O
3. I was not able to feel happy, even when my family or friends tried to help me feel better.	O	O	O	O
4. I felt like I was just as good as other kids.	O	O	O	O
5. I felt like I could not pay attention to what I was doing.	O	O	O	O

DURING THE PAST WEEK	Not at all	A Little	Some	A Lot
6. I felt down and unhappy.	O	O	O	O
7. I felt like I was too tired to do things.	O	O	O	O
8. I felt like something good was going to happen.	O	O	O	O
9. I felt like things I did before did not work out right.	O	O	O	O
10. I felt scared.	O	O	O	O

DURING THE PAST WEEK	Not at all	A Little	Some	A Lot
11. I did not sleep as well as I usually sleep.	O	O	O	O
12. I was happy.	O	O	O	O
13. I was more quiet than usual.	O	O	O	O
14. I felt lonely, like I did not have any friends.	O	O	O	O
15. I felt like kids I know were not friendly or that they did not want to be with me.	O	O	O	O

DURING THE PAST WEEK	Not at all	A Little	Some	A Lot
16. I had a good time.	O	O	O	O
17. I felt like crying.	O	O	O	O
18. I felt sad.	O	O	O	O
19. I felt like people did not like me.	O	O	O	O
20. It was hard to get started doing things.	O	O	O	O

Name:_____

Date: _____

Score: _____

Beck Anxiety Inventory

	Not at all	Mildly, but it did not bother me much	Moderately, it was not pleasant at times	Severely, it bothered me a lot
Numbness or Tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky/unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint/Lightheaded	0	1	2	3
Face flushed	0	1	2	3`
Hot/Cold Sweats	0	1	2	3
Column Sum				

Scoring – Sum each column. Then sum the columns totals to achieve a grand score.

Write that score here: _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

ID# DOB

Name Date

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   ○ Yes ○ No _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   ○ Yes ○ No _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   ○ Yes ○ No _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ○ Yes ○ No _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ○ Yes ○ No _____

6. Were your parents **ever** separated or divorced
   ○ Yes ○ No _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ○ Yes ○ No _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ○ Yes ○ No _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   ○ Yes ○ No _____

10. Did a household member go to prison?
    ○ Yes ○ No _____

_____ **This is your ACE Score**