Red Oak Counseling, Ltd.

Client Master Record

Client Legal Name: _____Preferred Name: _____

Date of Birth: _____ Age: _____Assessment Date: _____

Address: _____

City: _____ State: _____ Zip: _____
Gender: _____ Pronouns: _____

Relationship Status: □ Married □ Separated □ Partnered

□ Divorced □Widowed □Single/Never Married

Race: □ African American □ Caucasian □ Hispanic

□ Native American □ Asian □ Other

Contact Information:

Cell: _____ Work: _____

Home #: _____ Email Address: _____

Is it okay to leave a message at these numbers? (*Circle One*) Yes or No

SS Number: _____ Number of Family Members Supported by Income: _____

Estimated Income Per Year: _____ Employer: _____

Referred By: _____ Phone Number: _____

Emergency Contact Information

Emergency Contact: _____ Relationship to Client: _____

Home Phone: _____Work Phone: _____

Email Address: _____

In case of an emergency, I give permission for the staff at Red Oak Counseling to call the person listed above and/or (911) for medical assistance and to release any information that will allow for proper medical care.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

Payment Agreement

The following agreement states your financial obligations for psychotherapy and counseling provided by Red Oak Counseling, I understand that:

1) I am responsible for all the fees incurred. Individual, couples, and family sessions are based on a 50–60-minute session. The remaining 10 minutes of the session are used to plan for the next appointment or to follow-up on issues important to your treatment. A sliding fee scale is available to individuals without insurance.
   90791- Initial Assessment: $250
   90837/90847- Individual/Family Therapy: $225
   90853- Group Session: $140
   CNSLT- Correspondence Fee: $50 per letter
   Record Request Fee: Up to $30
   Charge for No Show/Late Cancellation: $90
2) All fees are due at the time of service. Red Oak Counseling reserves the right to attempt to collect any unpaid bills by reasonable means. If your account balance is not paid in full your account may be turned over to a collection agency & a collection fee up to 50% may be assessed to any unpaid balance. Non-payment of fees can be cause for termination from treatment.
3) We offer complimentary benefit checks for both in and out of network levels of care. The information you receive from us regarding your insurance benefits is what we are quoted from your insurance company & we cannot guarantee the accuracy of the information until we begin receiving the explanation of benefits, if we are informed by your insurance company that you have an unmet deductible, a co-payment and/ or coinsurance as part of your plan, that amount will be due at the time of service.
4) Our stipulated rates with the insurance companies that we contract with are subject to change at any time and may result in an increase to your out-of-pocket responsibility. We may not be aware of this change until the explanation of benefits is received.
5) No show appointments or appointments canceled without 24-hour notice will result in a $90 fee for psychotherapy services. I am aware that insurance plans will not reimburse me for late cancellations or for not showing up for appointments and it is my responsibility for payment at or before my next appointment.
6) I am authorizing Red Oak Counseling, Ltd. to bill my insurance company, EAP or other source of reimbursement for services incurred. In doing so, I also understand that my insurance company, EAP, managed care organization, or other source of reimbursement may require direct clinical management in the treatment process. This involvement will directly impact the confidentiality of my records.

Fee Statement

Name of insurance Company or Reimbursement Source: _____

Please check options that apply:

☐ I am self-paying and agree to pay $_____for the assessment,
$_____ for the individual/couples/family,
and $_____for group therapy.

☐ I am utilizing my insurance coverage and/or my EAP benefits.

I have carefully reviewed all the above statements and accept all the above conditions as indicated. If there are any changes in my insurance benefits, I will immediately inform Red Oak Counseling. If I fail to report changes, I agree to all charges.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

Health Information

Client Name: _____

Medical History:

Current Primary Care Physician: _____

Address: _____ Phone Number: _____

When was your last visit to your Primary Care Physician? _____

Please list any hospitalizations _____

Please list any serious injuries _____

Please list any chronic medical conditions _____

Current Medications:

Physician Prescribing Medication: _____

Name of Medication	Dosage	Reason for Medication

Are you currently pregnant? □ No □ Yes # of Months _____

Do you drink coffee of caffeinated soda? □ No □ Yes Amount: _____

Do you smoke cigarettes/cigars/chewing tobacco/vape? □ No □ Yes Amount: _____

Do you exercise on a regular basis (at least 3x per week)? □ No □ Yes

Nutrition Screen:

Have you noticed any appetite changes? □ No □ Yes

If yes, describe _____

Describe your weight □ Stable □ Weight Gain □ Weight Loss

How much did you gain or lose? _____

Have you been in counseling/psychotherapy in the past? □ No □Yes

If yes, how long ago? _____ Where? _____

Did you find it helpful? □ No □ Yes

Explain: _____

_____

Family History:

Mother's Name: _____ Age: _____ Health/Mental Health Problems: _____

Father's Name: _____ Age: _____ Health/Mental Health Problems: _____

Spouse's Name: _____ Age: _____ Health/Mental Health Problems: _____

Family History Continued:

Who raised you? □ Both Parents □ One Parent □ Grandparents □Other

Number of Brothers: _____ Number of Sisters: _____

Number of Children you have: _____ Ages: _____

Symptoms: Please check all that apply. Please be honest in identifying the symptoms so that appropriate care can be arranged.

o Avoidant	o Abandonment	o Abuse	o Affair	o Alcohol
o Anxiety	o Appetite	o Blended Family	o Body Image	o Children
o Codependent	o Compulsions	o Conduct	o Crisis	o Depression
o Disability	o Disorganized	o Distractible	o Divorce	o Drugs
o Enabling	o Family Conflict	o Fear	o Grades	o Grief
o Hyperactive	o Idealization	o Inactivity	o Inattentive	o Inhibition
o Jealousy	o Legal Problems	o Marital	o Medical	o Memory Loss
o Oppositional	o Pain	o Panic	o Rage	o Rationalization
o Resistance	o Ruminative	o School Problems	o Self-Absorption	o Self Esteem
o Shame	o Social Skills	o Sleep	o Stress	o Trauma

Please Provide any additional information that you feel is important to your care:

_____

_____

_____

_____

Please list your goals for therapy/other services:

_____

_____

_____

_____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Consent for Treatment

The mission of Red Oak Counseling is to enhance the well-being of individuals and families in a way that blends traditional and innovative approaches, creating an atmosphere of dignity and respect while fostering hope and encouragement for our clients.

For the best results and for your own welfare, it is very important that you take the time to read and understand what it means to be receiving psychotherapeutic services from Red Oak Counseling. Please read the brief description below. If you understand it and you choose to receive therapeutic services from Red Oak Counseling as described here, sign and date this form and return it to your intake interviewer. If you have any questions of concerns, you are urged to talk about them with your intake interviewer.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you solve problems that may be limiting your satisfaction in life, and help you cope better with the feelings and challenges that you encounter in daily life.
2. The most common method of psychotherapy involves you talking about your feelings, your problems or concerns, and your experiences and your situation. Other common methods involved using your imagination, keeping personal records of your experience, and trying new and/or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions, or you may be asked to do them at home.
3. The length of psychotherapy often depends on your individual needs and the rate of your progress toward the agreed upon goals in your treatment plan. Many therapists use periodic reviews as a means of evaluating your needs, progress and satisfaction, and treatment plans are reviewed every three months at Red Oak Counseling.
4. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your psychotherapist. If you feel that your therapist has attempted to violate you in any way- financially, physically, sexually, or otherwise- you should inform the state agency responsible for professional licensing. You are also encouraged to contact the clinical director at the agency at any time with any concerns or feedback you may have about your therapist.
5. You always have the right to choose whether to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist or the Clinical Director at the agency should be able to offer information on possible referrals. Local mental health agencies are listed in the telephone book, and they may also offer helpful information. Sometimes it is helpful to participate in different kinds of counseling in addition to or instead of psychotherapy. Some different kinds of counseling are self-help or support groups, therapeutic reading, and different forms of religious or pastoral counseling. The agency strongly supports you making the decision to participate in therapy that feels right for you. We will help you to the best of our ability acquire appropriate care.
6. Communication is essential to successful psychotherapy. You are urged to ask questions, express concerns, and share information about your personal life with your therapist. This information must be kept private (confidential) by your therapist unless you grant permission to release it. The only exception to this protection of your privacy is dictated by laws and are explained in the Limits of Confidentiality form that will be reviewed with you. If you do not understand the limits of confidentiality you are urged to discuss them with the intake counselor or your therapist.
7. Red Oak Counseling's mental health providers are a diverse group from various disciplines. They include psychiatrists, nurse prescribers, psychologists, professional counselors, social workers, marriage, and family therapists, as well as graduate school interns from several graduate programs in the state. All other providers are licensed (fully licensed and/or in-training licensed) professionals or are actively working towards their licensure through continuing education and supervision. All providers receive supervision, meaning they consult and collaborate with other mental health professionals within our agency about their clients without divulging the client's names or identifying information. If you have any questions about your therapist or about consultation/collaboration between providers, please do not hesitate to ask him or her, or the Clinical Director.

Audio or Video Recording of Any Session is Forbidden

I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). If I or any participant in my session do record any audio or video information during my treatment session(s)

without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I may be permanently discharged from my provider and all providers in the Red Oak Counseling company.

Client Information and Informed Consent for Telehealth Treatment

Telehealth services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for services such as individual, couples, or family therapy. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with the technology (cell phone, computer, etc.) which is being utilized. It is important that both the client and the counselor be in a place where there is the most privacy, as possible, during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

Additional Points for Client Understanding:

• I understand that telehealth services are completely voluntary, and I can choose not to do it or not to answer questions at any time.
• I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
• I understand the laws that protect privacy and the confidentiality of client information also apply to telehealth, and no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
• I understand that telehealth may be performed over a communication that is not encrypted. My therapist and I will work together to choose the telehealth communication system/program that will work best for my needs. I do accept the risk that this could affect confidentiality.
• Red Oak Counseling has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
• I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing, text, or telephone connections are not adequate for the situation.
• I understand that I may experience benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
• I understand if there is an emergency during a telehealth session, as with an in-person session, my therapist will call emergency services and my emergency contacts if needed clinically necessary.
• I understand that in advance of the telehealth session, a plan will be in place about how to re-connect if the connection drops while I am in a session.
• I understand that my therapist and I will create and have in place a safety plan in case of an emergency (see below).
• I understand I have the right to withhold or withdraw this consent at any time.
• I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document.

Consent:

I consent to engaging in telehealth as part of my treatment at Red Oak Counseling. I understand telehealth includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or data communications.

I understand the information provided above regarding telehealth. I have discussed the consent with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE/EAP BENEFITS

Please Indicate Your Preference By Checking Either A or B Below:

☐ **A.** I hereby authorize Red Oak Counseling to release to my insurance company, EAP, and/or associate professionals any information from my medical records which may be necessary to determine benefits payable under my policy and/or expedite treatment. This information may be transmitted electronically with appropriate assurances for confidentiality. I further authorize payment directly to Red Oak Counseling for the benefits of otherwise payable to me for the amount which covers but does not exceed changes for services delivered. I hereby guarantee payment of all changes incurred for services rendered which are not covered by this assignment or by insurance benefits. I am also aware that any co-payments are expected at the time of service.

I understand that if the person(s) and/or organizations listed above are not health care providers, health plans or a health care clearing house, who must follow the federal privacy standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed without my authorization.

Please Note: If consent has been given to release information to my insurance company, I understand that some communications may be transmitted be facsimile ("fax") or electronically. Although every attempt is made to ensure confidentiality of these transmissions, the nature of this method cannot absolutely guarantee confidentiality.

☐ **B.** I **DO NOT** authorize my insurance/EAP company to be billed and I **DO NOT** authorize any information from my medical records to be released to my insurance company. I understand that I am solely responsible for private payment of all charged incurred with Red Oak Counseling. I am aware that payment for service is expected at the time of service.

A Mental Health and AODA Clinic
Confidentiality of Alcohol and Drug Abuse Client Records

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by the clinic. Generally, the clinic may not say to a person outside of the clinic that a client attends the clinic, or disclose any information identifying a client as an alcohol or drug abuse client unless:

1. The client consents in writing.
2. The disclosure is allowed by court order
3. The disclosure is made to medical personal in a medical emergency

Violation of the Federal law and regulations by the clinic is a crime. Suspected violations may be reported to the appropriate authorities in accordance to Federal regulations.

Federal Law and regulations do not protect any information about a crime committed by a client either at the clinic or against any person who works for the Clinic or about any threat to commit such crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for federal regulations.

Confidentiality of Mental Health Client Records

All information concerning your identity and all treatment information in your files at Red Oak Counseling shall remain confidential. Your records shall be released without your written informed consent **ONLY** as provided under sections 46.21, 46.215, 51.30, and 146.81, et seq., of Wisconsin State Statues, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3. of the federal state statutes, 42 C.F.R. Part 2 of the federal regulations, or as otherwise allowed or required by state or federal law. They may also be released to other persons with your written informed consent, or the written informed consent of a person authorized by you. Feel free to request additional information or have your Therapist/Counselor explain the circumstances under which your records may be released if you wish further clarification.

You are not required to give Red Oak Counseling any specific information. However, all information that you give will help us gain fund for the services you may receive.

All information that you give will also help your Therapist/Counselor provide you (and your family) with the best care possible. Feel free to have your Therapist/Counselor explain further if you wish clarification.

You have the right to review your file with staff present and to contest the accuracy of any statement in your file with which you disagree.

Grievance Procedures Outline

Red Oak Counseling is devoted to providing competent mental health and AODA Treatment to our clientele. The agency would also like every client to know that he/she does have a voice in the kind of care received. Grievances involve complaints about service, breach of confidentiality or abuse. The following instructions are steps to be taken should a client feel the need for resolution of a situation. If level one does not provide satisfactory results, the client should proceed to the next level, and so on.

Level One

One of the most important tools is psychotherapy is the relationship between the therapist and the client. If a client has a discrepancy with the therapist, those issues should be discussed directly with the therapist. The two parties will discuss the matter and come to an agreeable resolution. If the therapist is a student intern, the student should bring the issue to the attention of the clinical director.

Level Two

Clients of **Red Oak Counseling** have the right to speak directly to the Clinical Director if speaking with the therapist has not helped. The Clinical Director will attempt to mediate the difficulties between therapist and client.

Level Three

At this level, clients should place all grievances and steps that have been taken to remedy the situation in writing using the "Grievance and Complaint Summary Form" within one month of the meeting with the Clinical Director. This form may be obtained from the Client Rights Specialist/ Director. The Director will review the situation and meet with the parties involved to discuss resolution. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

Acknowledgement of Receiving "Notice of Privacy Practices"

I acknowledge that I have received the written "Client Bill of Rights and Grievance Procedure for Community Services" under Wisconsin Statute sec. 51.61 (1) and HFS 94 and the Notice of Privacy Practices as explained by staff of Red Oak Counseling/Refresh Mental Health. I understand the "Client Bill of Rights and the Grievance Procedure for Community Services" and the Notice of Privacy Practices and confirm my understanding of both by signing this acknowledgement.

I have read and understand the above confidentiality policy of client records. I understand that my records may be released to other persons without my informed consent only as provided by State and Federal law, or to persons with my informed consent or the informed consent of a person authorized by me.

I have read the policy regarding the prohibition of audio and video recording. I agree to abide with this policy.

I have read the authorization to release information for assignment of insurance/EAP benefits, have indicated my preference, and am acknowledging my understanding of the information hereinabove.

Your signature indicates that you have understood the above description of psychotherapy and are consenting to psychotherapy & telehealth if applicable with the understanding that you retain the right to review and revise the decision at later points in time.

_____

Client Name Printed Date

_____

Client Signature Date

_____

Parent or Guardian Signature Date

_____

Staff Signature Date

Coordination of Care Between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. The information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Client Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Client Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified client. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.

Red Oak Counselingy is authorized to release protected health information related to the evaluation and treatment of:

Client Name _____ Date of Birth _____

Primary Care Physician Name _____ Primary Care Physician Phone Number _____

Primary Care Physician Address _____ City _____ State _____ Zip Code _____

2nd Provider Name _____ Second Provider Phone Number _____

2nd Provider Address _____ City _____ State _____ Zip Code _____

Disclosure may include the following verbal or written information: (Check all that apply)

□ Client Master Record	□ History & Physical	□ Laboratory/Diagnostic Testing Results	□ School Information
□ Discharge Summary	□ Medication Records	□ Behavioral Health/Physical Consult	□ Psychological Assessment
□ ER Record Report	□ Psychiatric Evaluation	□ Psychological Evaluation Testing Results	□Other _____
□ Substance Abuse Treatment Record		□ Summary of Treatment Records & Contract Dates	

_____ **I hereby refuse to give authorization for any release of information**

Signature of Client, Parent, Guardian, or Authorized Representative **Date**

Staff Member Signature **Print Staff Member Name** **Date**

Client Name: _____ Date: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

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**

Client Signature:_____ Date:_____

Parent or Guardian Signature:_____ Date:_____

Staff Signature: _____ Date: _____

Client Name: _____ Date: _____

Columbia-Suicide Severity Rating Scale (CSSRS) Screen Version

In the past month:

1.) **Have you wished you were dead or wished you could go to sleep and not wake up?** □ Yes □ No

2.) **Have you actually had any thoughts of killing yourself?** □ Yes □ No

If you answered "YES" to Question #2, please continue answering all remaining questions. If you answered "NO" to Question #2, please go directly to Question 6.

3.) **Have you been thinking about how you might do this?** *E.g., "I thought about taking an overdose, but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."* □ Yes □ No

4.) **Have you had these thoughts and had some intention of acting on them?** *As opposed to "I have the thoughts, but I definitely will not do anything about them."* □ Yes □ No

5.) **Have you started to work out or have you worked out the details of how to kill yourself? Do you intend to carry out this plan?** □ Yes □ No

6.) **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.* □ Yes □ No
If "YES", was this within the past three months? □ Yes □ No

******If you answered "YES" to any of the above questions, and you have concerns about your immediate safety, please call 911 or seek support from local crisis resources prior to your assessment with Red Oak Counseling.******

Client Name: _____ Date: _____

RED OAK COUNSELING
ALCOHOL AND DRUG SCREEN SELF-REPORT

- **To better understand your general health and functioning, please answer the following eleven questions about your alcohol and drug use by checking yes or no. Your responses will be kept confidential. These questions will be reviewed with you and your interviewer as part of the assessment process.**

1. In the last 12 months, has using alcohol or other drugs occasionally caused you to miss work or school, perform poorly at work or school, neglect your children, or fail to perform household duties?
□ Yes □ No
2. In the last 12 months, while under the influence of alcohol or some other drug, have you occasionally driven a car operated dangerous machinery (such as a power mower), or participated in potentially hazardous sports (such as swimming or rock climbing)?
□ Yes □ No
3. In the last 12 months, have you been arrested for driving while intoxicated, disorderly conduct, or any other substances related defense?
□ Yes □ No
4. In the last 12 months, have you continued to drink or use other drugs despite fights or arguments with people close to you expressing concern about your drug or alcohol use?
□ Yes □ No
5. In the last 12 months, have you been consuming more alcohol or drugs than you originally intended to at a given time, or does your drinking and drugging go on longer than you originally intended?
□ Yes □ No
6. In the last 12 months, have you been wanting to cut down, or have you tried to stop or cut down, and have not been able to?
□ Yes □ No
7. In the last 12 months, has your tolerance increased- does it take more alcohol or drugs than it used to take to get you high, or achieve the desired effect? Or does a given amount have less effect than it used to?
□ Yes □ No
8. In the last 12 months, have you had any withdrawal symptoms? For instance, have you felt shaky the morning after drinking or thick headed after smoking marijuana, or paranoid after using cocaine?
□ Yes □ No
9. In the last 12 months, have you spent a significant amount of time procuring alcohol or drugs, using alcohol or drugs, or recovering from their effects?
□ Yes □ No
10. In the last 12 months, have you been spending more time drinking or drugging and less time with friends and family, in work or school related activities, or pursuing hobbies, sports or other interest?
□ Yes □ No
11. In the last 12 months, have you experienced any emotional or physical side effects- such as depression, anxiety, liver damage, or stomach trouble- but continues to use drugs or alcohol anyway?
□ Yes □ No

AODA Screen Outcome: _____
(Staff Only!)
Staff Signature: _____ Date: _____

CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM

Client First Name: _____ Client Last Name: _____

Client Date of Birth: _____

Red Oak Counseling, Ltd. ("Center") is committed to ensuring clients' satisfaction of services received. Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

☐ I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: _____

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **262-780-1020** or via email message at **help@redoakcounseling.com**. I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise by contacted by Center.

☐ I do not wish to be contacted for purposes of this survey.

Signature:

I confirm that I have read and fully understand the above information prior to my signing and all my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel such consent in writing pursuant to the terms set forth above.

Signature of Client or Responsible Party: _____Date: _____

Printed Name of Client (or Responsible Party): _____

Responsible Party's Relationship to Client: _____

Credit Card Authorization Form

Clinic Name: **Red Oak Counseling**

Card Holder Name: _____ Date: _____

Client Name (if different):_____

Card Number: _____Exp. Date: _____

CVV/CVC Code: _____Zip Code:_____

Card Type (Circle One):

● Master Card ● Visa ● Discover Card ● American Express

Signature: _____

☐ I authorize Red Oak Counseling to use this card for all future sessions, balances and/or missed appointments.

☐ I authorize Red Oak Counseling to use this card for telehealth sessions only.

☐ I authorize Red Oak Counseling to use this card for a one-time payment only.

Amount: _____