OMEGA
MENTAL HEALTH
2547 W Shaw Ave Suite #117
Fresno, CA 93711
Tel 559-412-7799
Fax 559-241-0105

# File Checklist

## Child Packet

### Left Side of Folder

Court Orders
Letters/Correspondence
ROIs

### Right Side of Folder

Consent for Treatment
Therapeutic Contract
Receipt of PP
Other Omega documents
Problem Area Checklist

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| | | | | | |
|---|---|---|---|---|---|
| __ Overly active | __ Can't sit still | __ Easily distracted | __ Poor communication | __ Impulsive | __ Restless |
| __ Does not do as asked | __ Argues with adults | __ Back talks | __ Trouble | __ Bossy | __ Hits kids |
| __ Teases or is teased | __ Irritable | __ Temper outbursts | __ Destructive | __ Hits adults | __ Threatens others |
| __ Steals | __ Meant to animals | __ Lies | __ Gang involved | __ Alcohol/ drug use | __ Ran away from home |
| __ Fire starting | __ Juvenile Hall involved | __ History of physical abuse | __ History of Foster Care | __ Grades dropped | __ Doesn't complete homework |
| __ Difficulty with school work | __ Truant | __ Tardy often | __ Has been suspended | __ Says is sad | __ Looks sad |
| __ Suicidal thoughts | __ Is tearful | __ Low self-esteem | __ Hopeless | __ No friends | __ Stays to self |
| __ Overly tired | __ Reduced activity | __ Reduced interest | __ Cuts on self | __ Too little sleep | __ Too much sleep |
| __ Wakes up at night | __ Wets bed | __ Wets or soils self during the day | __ Too little eating | __ Too much eating | __ Concerned with diet |
| __ Forces self to vomit | __ Often worries | __ Often afraid | __ Afraid of the dark | __ Afraid to go to school | __ Afraid due to familly problems |
| __ Clingy | __ Daydreams | __ Shy | __ Headaches/ stomach aches | __ Often in Nurses office | __ Stays home due to illness |
| __ Sexual problems | __ Sexual Activity | __ History of molestation | __ Hears things | __ Sees things | __ Strange thinking or behaviors |

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****(Please read the following below. Ask your therapist for a copy if you would like one)**
**Consent for Treatment**

I _____ authorize and request that _____, _____/Omega Mental Health to carry out a clinical assessment and therapeutic treatment which now or during the course of the treatment of Myself / Child are advisable.
(Circle one above)

**Office Policies**

**Litigation / Court:**
I / Omega Mental Health, will not be involved in litigation unless required by law. If required by law my fee is $300.00 per hour with a 4-hour minimum and payment must be paid by cash, check, or money order. Payment is due before the court date. This charge is not payable from the insurance company. You will be responsible for this charge.
I /Omega Mental Health also will not write any letters or fill out any forms on your behalf as it relates to litigation or court unless required by law.

**Insurance Reimbursement:**
Any co-payments for insurance reimbursements must be made at the time services are rendered. If billing a PPO insurance, then you must bill your own insurance. I will provide you with the appropriate billing information, which you will send for reimbursement.
** You are responsible for checking your insurance coverage and confirming certain coverage for examples at times family or couples is not covered. If you start treatment and we find out these are not covered, you are responsible for the full fee that we would charge your insurance. If you change insurance carriers you are responsible for letting us know.

**No-Shows/ Cancellation:**
Since an appointment time is reserved specifically for you, telephone notice is required 24 hours in advance for rescheduling or cancellation of an appointment.
** Please note up to the full fee can be charged for missed appointments without proper notification.
Most insurance companies will not reimburse for missed sessions
** Even with a phone call to cancel if there are two cancellations within 2-3 months your case will be closed as multiple cancellations are not conducive to your progress in therapy.

- By signing below, you are stating that you agree that we can charge your card on file for the above if needed.

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**Health and Safety:**
If anyone in your household has (or you suspect they have) bed bugs, fleas, lice, or any other highly communicable infestation we ask that you leave and not return until the issue is resolved. This is for the protection of all the many clients and clinicians who are in and out on a regular basis. Please be sure to let your clinician or an office staff member know of any condition regarding this policy.

**Contact information:**
If you need to contact me between sessions, please call me at the above number and leave a message and contact number where you can be reached. I will return your call as soon as possible. Office hours are Monday – Friday 9am-6pm. You may also e-mail me at the e-mail address listed on my card.

**Emergency Procedure:**
An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency arises, and the emergency requires it, please call your physician, 911 or admit yourself to a hospital for observation as I may not always be available. You may then call the office and we can arrange an earlier session.

I have read and understand these policies:

_____ _____ _____
Name Printed (*Self if 12 or Over*) Date Signature

_____ _____ _____
Name Printed (*Parent or Guardian*) Date Signature

_____ _____
Clinician with Omega Mental Health Date

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**Therapeutic Contract**

The therapy process: Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits however, requires effort on your part and may result in you experiencing some discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. As part of my therapeutic process I use several techniques pulled from various theoretical approaches to help improve the quality of life for my clients.

Client's Rights: you have the right to a confidential relationship with me. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
    - Revealing to me active child or elderly abuse or neglect. If a perpetrator is in contact with the victims and there is reasonable suspicion he/she may still be engaging in such abuse I am legally mandated to make a report.
    - Revealing active or past abuse of a child that resulted in the child's death, I am legally mandated to make a report. .
    - If you seriously threaten harm or death to another person I am required to warn the intended victim and notify the appropriate law enforcement agencies.
    - If you are in therapy or are being tested by court order, the results of the treatment or tests must be revealed to the court.
    - If a judge issues a legitimate subpoena, I am required to provide the information specifically described in that subpoena.
    - If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.
    - If you state or I have reason to believe you will harm or kill yourself, I will take the necessary steps for your protection.
4. You have the right to ask questions about any of the techniques used in the course of your therapy.
5. Should you choose not to enter therapy with me, I will provide you with the names of other qualified professionals whose services you might prefer.

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6. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you have already incurred. I have the right to terminate therapy with you under the following conditions:
   - When I believe that therapy is no longer beneficial to you.
   - When I believe that you will be better served by another professional.
   - When you have not paid for the last two sessions.
   - When you have failed to show up for your last two therapy sessions without a cancellation phone call.
   - If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent I will provide that professional with information they request.

   If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of several therapists for future counseling needs.

As life can bring about unexpected circumstances, should I be unable to continue your therapy, I will have a trusted therapist contact you to discuss what would be best for you at the time.

**Fees and Length of Therapy:**

I agree to enter therapy with Omega Mental Health Date . I agree to pay the standard fee of $_____ for each completed fifty minute individual session. I will make payment in cash or by check at the time of the therapy appointment, unless special arrangements have been made. I understand that I can leave therapy at any time and I have no financial, legal, or moral obligation to complete a maximum number of sessions. I am contracting only to pay for completed therapy sessions, or sessions I miss without providing notice.

_____ _____
X Client Signature Date

_____ _____
X Parent/Guardian Signature Date

_____ _____
X Therapist Signature & Title
Omega Mental Health Date


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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you (the client or parent/guardian of client) acknowledge receipt of the Notice of Privacy Practices that I (the provider) have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my Notice, you may obtain a copy of the revised Notice by contacting me at (559) 412-7799.

If you have questions about my Notice of Privacy Practices, please contact me at:

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I acknowledge the offer or receipt of the Notice of Privacy Practices of Omega Mental Health.

_____ _____

Signature of Client or Parent/Guardian Date

## INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my client's acknowledgement of their receipt of my Notice of Privacy practices including:_____

However, because of the following reason(s) the acknowledgement was not obtained:

_____

_____

_____

I was unable to obtain my client's acknowledgement.

_____ _____

Signature of Provider Date

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You will be receiving counseling services from the person indicated below. He/she is one of our unlicensed staff and is working under the supervision of a licensed clinician.

Student Name: _____

Supervisor's Name: _____

License Number: _____

_____

I acknowledge that I have received the above information and my therapist's information is noted above.

_____ _____
Signature Date

_____ _____
Parent / Guardian Signature Date
(If applicable)

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# Counseling Intake Form

This information will be kept confidential.

## Demographic Information

| | |
|---|---|
| Name: | Date: |
| Date of Birth: | Marital Status: |
| Age: | SSN: |
| Race: | Ethnicity: |
| # of Dependents: | Gender: |
| Home/Mobile Phone: | Ok to leave message? |
| Work Phone: | Ok to leave message? |
| Email: | Ok to email? |
| Mailing Address: | |
| Current Employer: | Position/Title: |
| Occupation Status? | |
| Gross Annual Income: | # of members in household: |
| Primary Medical Ins: | ID #: |
| Group #: | Subscriber Name: |
| Insurance Phone: | Subscriber DOB: |
| Emergency Contact Name: | Subscriber SSN: |
| How were you referred: | If online, which website? |

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Counseling Intake Form Page 2

This information will be kept confidential.

Current Concerns

What concern brings you to us?

When did this begin to be a problem for you (dates)?

Please describe significant events occurring at that time, or since that time, that may be related to the development or maintenance of this concern.

Are you having difficulty or increased stress in your current job? If so please briefly describe those difficulties.

What goals do you hope to accomplish in counseling?

What obstacle might get in your way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please provide approximate dates of treatment(s) and describe results:

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Counseling Intake Form Page 3

This information will be kept confidential

## Behavior – please circle any of the following that apply to you.

| | | | |
|---|---|---|---|
| Overeating | Attempted suicide | Can't keep a job | Use alcohol or illegal drugs to cope |
| Compulsive behavior | Insomnia/can't sleep | Smoking (and want to stop) | Find myself doing risky things |
| Odd behavior | Withdrawn socially | No motivation | Nervous tics |
| Obsessing about my weight | Crying for no reason | Very impulsive | Overwork myself |
| Procrastinating too much | Sleep too much | Lose control easily | Temper outbursts |
| Racing thoughts | Tapping, fidgeting constantly | Pull hair or skin | Physical violence |

## Feelings – please circle any that apply to you.

| | | | | | | |
|---|---|---|---|---|---|---|
| Angry | Guilty | Unhappy | Annoyed | Happy | Bored | Sad |
| Conflicted | Restless | Depressed | Regretful | Lonely | Anxious | Hopeless |
| Contented | Fearful | Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous | Others: | |

## Physical – please circle any that apply to you.

| | | | | | | |
|---|---|---|---|---|---|---|
| Headaches | Stomach trouble | Skin problems | Dizziness | Tics | Dry Mouth | Palpitations |
| Fatigue | Burning/itchy skin | Muscle Spasms | Twitches | Chest pains | Tension | Neck pain |
| Rapid heartbeat | Sexual issues | Tremors | Can't relax | Fainting spells | Blackouts | Bowel disturbances |
| Hear things | Excessive sweating | Tingling | Watery eyes | Visual difficulties | Numbness | Blushing/flushed |
| Hearing problems | Don't like to be touched | | | | | |

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## Biological Factors

Do you have any medical conditions or physical issues? (please list):

Medications you are taking or have taken in the past six months (Include over the counter medications):

Do any of your maternal or paternal relatives have mental health diagnoses or substance abuse issues (please specify):

Do you exercise regularly, and if so, how often/what kind of exercise:

| | Never | Rarely | Often | Very Often | | Never | Rarely | Often | Very often |
|---|---|---|---|---|---|---|---|---|---|
| Marijuana use | | | | | Heart problems | | | | |
| Tranquilizer use | | | | | Nausea | | | | |
| Sedatives | | | | | Vomiting (voluntary) | | | | |
| Aspirin | | | | | Vomiting (involuntary) | | | | |
| Cocaine | | | | | Insomnia | | | | |
| Coffee | | | | | Headaches | | | | |
| Alcohol | | | | | Backaches | | | | |
| Cigarettes | | | | | Wake too early | | | | |
| Narcotics | | | | | Can't get to sleep | | | | |
| Stimulants | | | | | Junk food | | | | |
| Hallucinogens | | | | | Lack of interest in activities | | | | |
| Diarrhea | | | | | Constipation | | | | |
| Compulsive exercise | | | | | High blood pressure | | | | |
| Use of laxatives to lose weight | | | | | Allergies | | | | |