CLARITY COUNSELING, INC.
CONTACT INFORMATION SHEET

(Please keep Clarity Counseling, Inc. updated if there are changes to the information in this packet)

BASIC INFORMATION

Full Name: _____

Date of Birth: _____

SSN: _____

Full Address: _____

Phone: _____

Email Address: _____

MEDICAL INSURANCE INFORMATION

☐ Medicaid (Specify Provider): _____
Medicaid Number: _____

☐ Medicare (Specify Provider): _____
Medicare Number: _____

☐ Other (Specify Provider): _____
Member Number: _____

Primary Care Doctor's Name: _____
Phone Number: _____

EMERGENCY CONTACTS

Name, Relation, and Number: _____

Name, Relation, and Number: _____

CLARITY COUNSELING, INC.

INTAKE FORM

Name:_____ Date of Birth:_____

Gender:_____ Religious Background: _____

Family of origin information (include name, age, and type of relationship with each family member):

Father: _____

Mother: _____

Sibling(s): _____

Others: _____

Currently living with (include name, age, and type of relationship): _____

_____

_____

Educational Background (schools attended, performance, behavior, areas of interest, and graduation, if applicable):

_____

_____

Legal History:
Ever been arrested? _____If yes, indicate arrested for what and when: _____

_____

Developmental History: Any significant developmental issues? _____ If yes, describe_____

_____

Medical History: Any medical issues? _____ If yes, describe_____

_____

Date of last medical exam: _____ Medical Doctor & Phone #:_____

Psychiatric History: Attended counseling previously? _____If yes, describe_____

_____

Medications: Are you currently taking medications? _____If yes, describe _____

_____

Allergies: Any known allergies (medications or otherwise)? _____If yes, describe _____

_____

Alcohol/Drug Usage: Currently use alcohol or drugs? _____ If yes, describe (e.g., types, frequency, past history):_____

_____

Abuse History: History of being physically, emotionally, or sexually abused? _____ If yes, describe_____

_____

Other Trauma: Experienced past trauma? _____ If yes, describe_____

_____

Death/Loss: History of significant losses? _____ If yes, describe_____

_____

Suicide Risk: Ideation or attempts (past and/or present)? _____

If yes, when? _____ How many times?_____

What were the circumstances at the time?_____

Circle the following symptoms/behaviors experienced in the last thirty days:

Sleep Disturbance	Weight Change	Lack of Motivation	Withdrawn
Change in Eating Behavior	Restlessness	Physical Complaints	Easily Annoyed or Irritated
Bedwetting	Uncontrolled Temper Outbursts	Guilt/Remorse/Shame	Cruelty Towards Animals
Nightmares	Uncontrolled/Unprovoked Crying	Lack of Concentration	Feelings of Depression
Generalized Anxiety	Difficulty with Decisions	Specific Anxiety	Panic Attacks
Aggression	Nervousness	Fear	Self-Harming Behavior
Tension	Negativistic		

Others:_____

Support Systems: Are there people who are supportive? _____ If yes, indicate name and contact information (in the event of an emergency) _____

Strengths: Personal strengths? _____

_____

Presenting Issues: Briefly explain reason for seeking counseling at this time:_____

_____

Goals for counseling:_____

_____

Other important information: _____

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

A written record of visits will be kept in your file. The record contains identifying information about you. It may also contain clinical information (such as a diagnosis, an assessment of functioning, reports from other people that support you, etc.).

Your rights under the Federal Privacy Standards include, but are not limited to, the following:

- You may request restriction on uses and disclosures of your health information for treatment, payment and healthcare operations.
- You may receive a copy of this information statement if you desire.
- You may request that communication with you be made by alternative means. We will make every effort to honor reasonable requests.
- You may request a copy of your file. This will be arranged unless your therapist feels it would cause harm to you or others if that request were approved. If this circumstance should arise, a Clarity Counseling representative will review your file with you.
- We will notify you of individuals who have been given access to your information based upon your written release.

CLARITY COUNSELING INC.:

- Will keep all of your information private. Reasonable environmental and administrative safeguards are in place to meet this objective.
- We will train clinical and administrative personnel regarding your rights to privacy and confidentiality.
- We will attempt to mitigate any breach of your privacy and confidentiality to the best of our ability.

The effective date of this notice is May 15, 2005.

If you desire, you may call our office to receive more information about circumstances where you as well as others may gain access to your information.

RECEIPT AND ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Service Recipient: _____

Date of Birth: _____ Social Security Number: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Notice of Privacy Practices of Clarity Counseling, Inc. I understand if I have any questions regarding the Notice or my privacy rights, I can contact Ron Olguin Jr., Privacy Officer.

_____

Signature of Service Recipient Date

_____

Signature of Parent, Guardian or Personal Representative* Date

❑ Service recipient refuses and/or is not able to sign.

_____

Signature of Clarity Counseling, Inc. Representative Date

** If you are signing as a personal representative of an individual, please describe your legal authority to act for individual (e.g., power of attorney, surrogate healthcare decision maker).*

CLARITY COUNSELING, INC.
2617 Juan Tabo NE Suite C, Albuquerque, NM 87112
Phone: 505-294-2722 * E-mail: claritycounselinginc@outlook.com

CONSENT FOR TREATMENT

STATEMENT OF DISCLOSURE: *Ron Olguin Jr. and Tara Sue Olguin both have a master's degree in counseling. They are Licensed Professional Clinical Counselors (LPCCs). Each one has supported people with mental health issues and/or disabilities (MR, CP, autism spectrum, etc.) for over 25 years. They have clinical experience with a wide range of mental disorders, including developmental disorders, various mental illnesses (e.g., mood disorders, delusional disorders, anxiety disorders, personality disorders), and neurological disturbances (including traumatic brain injury). They incorporate various approaches into their clinical work. They commonly use a variety of cognitive and behavioral techniques. They work towards evaluating someone holistically, to address underlying causes of behavior, and to build upon personal strengths and supports. Additional information can be shared during the initial appointment.*

I, _____, am authorized
(PLEASE PRINT FULL NAME AND GUARDIANSHIP STATUS, IF APPLICABLE)

to consent to treatment for _____.
(PLEASE PRINT FULL NAME OF SERVICE RECIPIENT)

As part of the therapeutic process, I understand that the following shall occur: clinical assessment (which may involve in-person interviews, phone calls, and document reviews), development of a treatment plan and related recommendations, and therapy sessions.

To acknowledge that you agree with each statement below, please place and "X" in each box.

- ☐ I have been informed about confidentiality and privacy (HIPAA) and how it relates to counseling services received through Clarity Counseling, Inc. I understand I will obtain more information during the first appointment.
- ☐ I authorize Clarity Counseling, Inc. to bill my insurance, as applicable.
- ☐ I understand that I will receive information about the therapeutic process (including intake and discharge), scheduling, cancelations, and emergency situations during my first appointment.
- ☐ I understand that Clarity Counseling, Inc. (CCI) is unable to accept Medicare. CCI is currently accepting a few insurance plans and private pay.
- ☐ I hereby authorize Clarity Counseling, Inc. to provide therapeutic services to the service recipient indicated above, including assessment, treatment, and referral (as deemed clinically appropriate).

_____ _____
Signature Date

CLARITY COUNSELING, INC.

PREFERENCE SHEET

Date:_____ Name: _____

We will use the following information to help us match you with a counselor. If we are unable to meet your specific needs and/or scheduling requirements, we will notify you as soon as possible. If this information changes before your first appointment, please send us an update. Thank you!

TYPE OF COUNSELOR:

Include any information that will be helpful (e.g., certifications/qualifications, therapy style, gender). If you do not have any specific preferences, please state that, as well.

TYPE OF APPOINTMENTS:

Please specify if you desire virtual or in-person appointments. If you have any other preferences, please indicate those, as well (e.g., length of sessions).

SCHEDULING AND AVAILABILITY:

Please describe your availability for sessions (e.g., days and times). If your schedule changes frequently, try to give a general description of what your schedule is like.

Please submit your completed packet one of the following ways:

Email: claritycounselinginc@outlook.com **Fax:** 505-445-0593

Mail: Clarity Counseling, Inc. 2617 Juan Tabo NE Suite C. Albuquerque, NM 87112