



Dear Client,

Thank you for your interest in Tahoe Youth & Family Services. We hope that the following information will help you complete this intake packet.

Tahoe Youth & Family Services believes that the family plays a significant role in the success of every family member's development and experience with our agency. Below are some tips to help you with the intake packet as well as the counseling experience.

- If a minor is the primary client, the only paperwork that is NOT to be filled out by, or about, the minor is the questionnaire marked "Parent/Guardian Questionnaire" on the top right corner.
- Please be on time for your scheduled appointment. **We require a 24-hour notice of cancellation** so that we may plan accordingly. Tahoe Youth & Family Services' policy is to discharge clients after 2 cancellations without prior notice.
- **Please bring only those children being seen for your scheduled appointment.** You will find that our lobby is not conducive to waiting with young children for an hour.
- Please be aware that TYFS accepts credit/debit cards and cash (exact change) only.

We truly hope that you find your experience with Tahoe Youth & Family Services to be helpful and positive. Should you have any concerns or questions, please do not hesitate to ask. Information provided on the questionnaire is confidential unless it is dangerous to self or others.

Thank you for choosing Tahoe Youth & Family Services.

Tahoe Youth and Family Services Offices and Drop In Center Locations

*Gardnerville Office
1512 Hwy 395, Suite 3
Gardnerville, NV 89410
Ph (775) 782-4202
Fax (775) 782-5055*

*South Lake Tahoe Office & Drop In Center
1021 Fremont Ave.
South Lake Tahoe, CA 96150
Ph (530) 541-2445
Fax (530) 541-0517*

***Crisis Line (800) 870-8937
www.tahoeyouth.org***



CLIENT (Youth 10-17 years)
CONFIDENTIAL QUESTIONNAIRE
To be filled out by the client (youth)

Today's Date: ____ / ____ / ____
 Client # Office Use Only: _____

PLEASE PRINT

Client Name: _____ Sex: M F Age: _____ DOB ____ / ____ / ____

Place of Birth: _____ Social Security #: _____
City State

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Client's Ethnicity/Race: _____

Client Marital Status: Single Married Divorced Partner Widowed

Disability: _____ School Name: _____ School Grade: _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Mother's Name: _____ Age: _____ DOB ____ / ____ / ____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Father's Name: _____ Age: _____ DOB ____ / ____ / ____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

If you do not live with any of the above, with whom do you live?

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

Who else lives in your home?

NAME AGE DOB DISABILITY

Sisters:

Brothers:

Roommates:

Other:

Has anyone felt concerned about your drinking or using? Yes No
 Do you feel concerned about your use? Yes No
 Do most of your friends use or drink? Yes No
 Have you ever overdosed on drugs or alcohol (alcohol poisoning)? Yes No
 Have you ever been to the emergency room or hospital? Yes No
 Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job? Yes No

If yes, please explain: _____

Have you ever used drugs to numb uncomfortable feelings? Yes No
 (boredom, sadness, anxiety, insomnia/sleeplessness)
 Have you ever received outpatient treatment for drugs or alcohol use? Yes No
 If yes, when and where? (includes TYFS outpatient, Juvenile Hall or other agency)

Has any family member received treatment for drug(s) or alcohol use? Yes No

If yes, when and where? _____

Have you ever been under the influence of drugs or alcohol? Yes No

Have you ever used any of the following? Please be honest.

THIS IS CONFIDENTIAL

Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Marijuana	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Spice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Hallucinogens (LSD, mushrooms, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Cocaine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Crack (Ice)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Methamphetamines (crank, speed)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Ecstasy (E)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Pills (codeine, oxycotin, vicodin, soma, valium, xanax, etc.)				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Inhalants, nitrous oxide				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Heroin, morphine, methadone				
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Over the counter medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How many times? _____	Age first tried: _____
Do you regularly smoke cigarettes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much/how often? _____	Age first tried: _____
Would you like help to quit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Please check all the behaviors or symptoms that you have experienced.

Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expressing severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Having nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt If yes, when _____	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind "going blank"	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardiness
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image ("I'm a loser")
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being "hyper"	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached ("in a daze" or "out of it")
<input type="checkbox"/>	<input type="checkbox"/>	Blaming others for your mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Being overly sensitive, "touchy", vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Initiating fights	<input type="checkbox"/>	<input type="checkbox"/>	Having access to guns or weapons
<input type="checkbox"/>	<input type="checkbox"/>	Being cruel to animals or people	<input type="checkbox"/>	<input type="checkbox"/>	Stealing things
<input type="checkbox"/>	<input type="checkbox"/>	Deliberately setting fire to or destroying other's property	<input type="checkbox"/>	<input type="checkbox"/>	Lying, manipulating, or "conning"



T A H O E
YOUTH & FAMILY
 S E R V I C E S
 A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

PARENT/GUARDIAN (Youth 10-17 years)
CONFIDENTIAL QUESTIONNAIRE
To be filled out by the Parent/Guardian

Today's Date: ____ / ____ / ____

PLEASE PRINT

Client's (Child's) Name: _____ Sex: M F Age: _____

DOB: ____ / ____ / ____ Social Security # _____ Insurance: _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Mother's Name: _____ Age: _____ DOB ____ / ____ / ____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

PLEASE CIRCLE ONE: Parent / Guardian / Step / Foster

Father's Name: _____ Age: _____ DOB ____ / ____ / ____

Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: (____) _____ -- _____ Cell Phone: (____) _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

The following will allow us to find out more about the problems you are dealing with. By giving these questions your full attention, you will help us better assist you; and it will help you to clarify the issues you want to work on.

Please list some of the problems you are encountering being a parent.

What are some of the current behaviors of your child (or children) that concern you the most?

In what ways have you tried to solve these problems on your own?

What past events do you feel may have contributed to the current problems/concerns?

Please list three goals you would like to accomplish for you, your child, or your family.

1. _____

2. _____

3. _____

Specifically, what do you feel we can do to help you and your child/children accomplish these goals?

Are you currently seeking services?

- Private Therapist/Counselor Name: _____
- Another Agency: _____

Who referred you here?

- Self
- Another Agency: _____

Please list any counselors, therapists, psychologists, psychiatrists, and/or doctors that you or your child has seen (evaluations, exams, testing).

Child	Dates of Services	Parent	Dates of Services

Have any of the following situations happened in your family? If so, when?

- Parents' divorce _____
- Custody battle, Is it current YES NO _____
- Primary Custodial Parent Name: _____
- Death in the family (Who? _____) _____
- Significant person leaving (Who? _____) _____
- Arrest (Who? _____) _____
- Accident or injury (Who? _____) _____
- Physical or sexual assault _____
- Major family illness (mental or physical) _____
- Recent move _____
- Family member in jail or prison (past ____ present ____) _____
- Pregnancy, self or parent _____
- Expulsion or suspension from school _____
- Witnessing a crime or being a victim of one _____
- Family member using drugs or alcohol (past ____ present ____) _____
- Adoption or Foster services _____
- Other: _____
- Have you had a history of cutting or self-harm? Yes No _____
- Have you had any suicide attempts? Yes No _____
- Any attempts without hospitalization? Yes No _____
- Do you have any relatives that have had serious mental or emotional problems? Yes No

If "yes", please list them: _____

Has your child experienced any trauma or stressors? Check all that apply.

- Accident
- Severe illness
- Physical, sexual, or emotional abuse
- Homeless Past Present
- Family member using drugs or alcohol Past Present
- Frequent changes in child care Past Present
- Learning disabilities Past Present Has your child been tested? Yes No

What was the treatment? _____

- Separation from parents or primary caregiver
- Does your child have a history of cutting, or other self-harm? Yes No

Has your child had any suicide attempts? Yes No Dates: _____

Any attempts without hospitalization? Yes No Dates: _____

Please check all the behaviors or symptoms that you believe your child has experienced.

Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expresses severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Has nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind "going blank"	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardiness
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image ("I'm a loser")
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Lies, manipulates or "cons"
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being "hyper"	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Often blaming others for his/her mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached ("in a daze" or "out of it")
<input type="checkbox"/>	<input type="checkbox"/>	Overly sensitive, "touchy", vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Initiates fights	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Cruel to animals or people	<input type="checkbox"/>	<input type="checkbox"/>	Has access to guns or weapons
<input type="checkbox"/>	<input type="checkbox"/>	Deliberately sets fire or destroy property	<input type="checkbox"/>	<input type="checkbox"/>	Steals things



FEE DETERMINATION

Thank you for choosing Tahoe Youth & Family Services.

We ask that you provide important basic information in order to assess your situation and find the appropriate funding source for your services. If we are unable to assist you, we will offer other appropriate referrals in the community.

Individual/Family sessions are 45-50 minutes.

Group sessions are 80 minutes in California and 50 minutes in Nevada.

Intensive Outpatient Program Groups sessions are 180 minutes in Nevada.

Services will not be provided, nor will verification of services be provided until all requested financial information is received, signed and processed. TYFS requires payment prior to the start of each session.

Yes No **CLIENT HAS HEALTH INSURANCE (MEDICAID, MEDI-CAL, PRIVATE INSURANCE: _____)**
 (Please provide a copy of the health insurance card & complete the insurance form on the back.)
 Co-Pay Required? Yes No Co-Pay Amount: Individual \$ _____ Group \$ _____
 Co-Insurance? Yes No Co-Insurance Percentage: _____%

Yes No **CLIENT QUALIFIES FOR ANOTHER FUNDING SOURCE? (TRYS, OC, _____)**
 Referral Required? Yes No Authorization needed? Yes No

Yes No **CLIENT WISHES TO PAY CASH FOR SERVICES (cash or card only, must be exact change)**
NOT INCLUDING the Intensive Outpatient Program
 \$125.00 charge for the 1st appt; \$95.00 charge per individual sessions; \$30.00 charge per group sessions.
 Session packages – 10 Individual Sessions for \$900.00 OR 10 Group Sessions for \$250.00

Yes No **CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A DRUG & ALCOHOL EVALUATION** because of a DUI offense, **MUST** have a copy of the court order, the charge is \$100.00 and is due prior to scheduling.

Yes No **CLIENT IS REQUESTING A REPORT BE SENT TO THE COURT BASED ON THE FINDINGS OF A MENTAL HEALTH EVALUATION** because of a court order or any other reason; the charge is \$315.00 for 3-sessions. Payment of \$157.50 (half of full payment) is also accepted prior to scheduling.

Yes No **INTENSIVE OUTPATIENT PROGRAM** (requires 4 individual sessions and 12 group sessions per month)
 \$1,490.00 a month; or \$395.00 1st week; \$365.00 2nd 3rd and 4th week.
 \$125.00 for the 1st appt; \$90.00 per group; \$95.00 for individual.
 Discount- If paid upfront 25% off = \$1,117.50 and is due prior to scheduling.

Signature: _____ Date: _____



Insurance Information

CLIENT INFORMATION PLEASE PRINT CLEARLY

Name: _____ Marital Status: Single Married Divorced Widowed Separated

Address: _____ Race/Ethnicity: _____

City: _____ State: _____ Zip: _____ 1st Language: English Spanish Other _____

Date of Birth _____ Check if minor (less than 18) Gender: M F 2nd Language: English Spanish Other _____

Soc. Sec. # _____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home Cell

Employer: _____ Work Phone: _____

Referring Agency _____ Referring Agency Phone: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Marital Status: Single Married Divorced Widowed Separated

Address: _____ Race/Ethnicity: _____

City: _____ State: _____ Zip: _____

Date of Birth _____ Gender: M F 1st Language: English Spanish Other _____

Soc. Sec. # _____ 2nd Language: English Spanish Other _____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Home Cell

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: M F

Soc Sec # _____ Employer: _____ Patient Relationship: Self Child Stepchild Spouse Other _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

Type of Coverage: Group Individual Is this a Retiree Plan? Yes No

Secondary Insurance Company: _____ Plan Phone: _____

Name of Person Insured: _____ Policyholder's DOB _____ Gender: M F

Soc Sec # _____ Employer: _____ Patient Relationship: Self Child Stepchild Spouse Other _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy ID# _____ Group # _____ Group Name _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Tahoe Youth & Family Services (TYFS) of all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered for me or for my dependents.** TYFS will estimate your copay as accurately as possible based on your insurance plan. Your actual share of cost will be determined by your insurance Explanation of Benefits. I authorize TYFS, the therapist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. **I have read and agreed to the above.** Rev 10.2017

X _____ Date: _____
Signature of Patient (If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/Guardian Name (Print) _____ Relationship to Patient _____



Monday-Thursday 9a-5p
(closed for lunch from 12p to 1p)
(775) 782-4202 or (530) 541-2445
24-hour voicemail

NO-SHOW and/or LATE APPOINTMENT CANCELLATION POLICY

Please call the office at least 24 hours before your scheduled appointment to make a change or cancellation. Regardless of your fee determination, the following fees will be levied:

1. A fee of \$50.00 will be assessed if I do not provide a minimum of 24 hours' notice when I need to cancel or change an appointment. _____ **(Please initial)**
2. A fee of \$50.00 will be assessed if I arrive 15 minutes late or more after the scheduled appointment. _____ **(Please initial)**
3. A fee of \$125.00 will be assessed if I miss an appointment without contacting the office to cancel the appointment. _____ **(Please initial)**
4. If I miss 2 sessions for unexcused reasons, I may be discharged from services at Tahoe Youth & Family Services' discretion. _____ **(Please initial)**

Please leave a message at ext. 100 if you are unable to reach a staff member by phone.

I understand that Tahoe Youth & Family Services is unable to contact me to remind me about appointments. I will receive an appointment reminder card upon scheduling an appointment to serve as my reminder (unless the appointment is scheduled over the phone.) I understand that I am encouraged to contact Tahoe Youth & Family Services at any time if I need to verify an appointment date and/or time. I understand that if any of the above fees are assessed, my appointments will be removed from the calendar until the fee is paid. At the time of payment, my new appointment will be scheduled based on the current availability.

I understand that insurance companies cannot be billed for these fees therefore they are solely my responsibility.

By signing below, I agree to the above policy and stated fees.

Signature: _____ **Date:** _____

TYFS Staff assisting client: _____ **Date:** _____