TAHOE YOUTH & FAMILY SERVICES

A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

ADULT

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.

- 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

Gardnerville Drop In Center
1307 Langley, Unit 1
Gardnerville, NV 89460

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

Alpine County Office
Early Learning Center
100 Foothill Rd., Bld. D, Room 5
Woodfords, CA 96120
Ph (530) 694-9459

Text 'tahoeyouth' to 839-863 ● Crisis Line (800) 870-8937
www.tahoeyouth.org

TAHOE YOUTH & FAMILY SERVICES
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ADULT

CONFIDENTIAL QUESTIONNAIRE

Today's Date : _____

Client # (Office Use Only) _____

PLEASE PRINT

Client's Legal Name: _____Nickname: _____

DOB: _____/____/_____ Age: _____ Sex: ❑ M ❑ F SSN: _____

Birthplace: _____Mother's Full Name_____
City State

Home #: _____ Work #: _____ Cell #: _____

May we leave a message: ❑ Y ❑ N Would you like to receive our newsletter by email? ❑ Y ❑ N

E-mail Address: _____

Current address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

How long have you lived at the above listed residence: _____?

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner Ethnicity: _____

Primary Language: _____Secondary Language:_____

Present occupation: _____

Education: _____Highest degree achieved: _____

Emergency contact name: _____

Phone: _____ Relationship to client: _____

Do you have insurance: ❑ Y ❑ N. Please provide primary insured's Social Security #: _____

Name of Insurance Company: _____ Member ID #: _____

Do you have a court order for counseling? ❑ Y ❑ N. Referred by: _____

FAMILY HISTORY

Please provide information regarding your immediate family, including children. If you require additional space, please use the last page.					
First Name	**Last Name**	**AGE**	**DOB**	**Relationship**	**List substance abuse or other addictions, if any**

Have you ever been in counseling or therapy or been hospitalized for drug addiction/alcohol/mental health reasons? (Circle one.) Yes No If so, please list below:		
DATE	**LOCATION**	**LENGTH OF STAY**

Section 1

Have you ever experienced any of the following? (Please check all that apply)

Now	Past	
		Feelings of sadness or depression
		Feelings of hopelessness or guilt
		Thoughts of suicide
		Lack of caring about anything
		Isolation and/or trouble making or keeping friends
		Suicide attempt
		Losing temper often
		Anger, rage or fear towards certain people
		Low energy, sleeping more
		Withdrawal from family and close friends
		Hearing voices when not under the influence of drugs or alcohol
		Hallucinations when not under the influence of drugs or alcohol
		Head injury (date: ____/____/_____)
		Sexual abuse
		Physical abuse
		Emotional abuse
		Witnessed or experienced traumatic event (car crash, earthquake, etc.)
		Having access to guns or weapons

Section 2

Please list all medications you are taking now. If you need more space, please use the bottom of page 10.	
name and dosage of medication	**health condition requiring this medication**

Section 3

LEGAL ISSUES	WHEN/WHERE	OUTCOME

Section 4

Has anyone felt concerned about your drinking or using? ❑ Yes ❑ No

Do you feel concerned about your usage or drinking? ❑ 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 an emergency room/hospital for alcohol/drug related reasons? ❑ Yes ❑ No

Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job?

If yes, please explain: _____

_____

_____

Have you ever used drugs to numb uncomfortable feelings such as boredom, sadness, anxiety, insomnia (sleeplessness)? ❑ Yes ❑ No

Have you ever received outpatient treatment for drug or alcohol use? ❑ Yes ❑ No

If yes, when and where? This includes TYFS outpatient, TREC and SAP Program in Juvenile Hall._____

_____

Has any family member received treatment for drug or alcohol use? ❑ Yes ❑ No

If yes, when and where?

_____

_____

_____

Do you regularly smoke cigarettes? ❑ Yes ❑ No **How much/how often?** _____ **Age first tried:** _____

Would you like help to quit? ❑ Yes ❑ No

Are you currently pregnant? ❑ Yes ❑ No

Section 5

Substance Use History					
Substance Type	**How often do you use this substance?**	**How long have you used this substance?**	**Age of first usage:**	**Date of last usage:**	**Route of Administration** (i.e. Oral, Smoking, Inhalation, Injection [IV or intramuscular,] other, etc.)
Alcohol					
Marijuana					
Hallucinogens **(i.e. LSD, Mushrooms, etc.)**					
Cocaine					
Crack (i.e. ice)					
Methamphetamine **(i.e. Crank, Speed)**					
Ecstasy					
Pills **(i.e. Oxycontin, Vicodin, Valium, etc.)**					
Inhalants					
Heroin, Methadone					
Over-the-counter Medication(s)					
"Spice"					
Other: **_____**					

Section 6

The following questions will allow us to learn more about your current concerns.

By giving these questions your full attention, you will help us better assist you.

1. **Please list some of the problems/issues you are encountering at this time.**

_____

_____

_____

_____

_____

2. **What are some of the current behaviors that concern you the most?**

_____

_____

_____

_____

_____

3. **In what ways, have you tried to solve these problems on your own?**

_____

_____

_____

_____

_____

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

_____

_____

_____

5. **Extra Notes Below:**

_____

_____

_____

Section 7

Please list three goals you would like to accomplish for yourself/family.

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

Specifically, what do you feel we can do to help you accomplish these goals?

_____

_____

_____

Please use the space below for any additional thoughts or concerns you may have OR for any previous questions requiring more space.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature: _____ Date: _____

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

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 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.

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 a session. Payments may be made directly to TYFS' Client Advocates.

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? (DRYS, SAPTA, TRYS, _____)
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)
$95 charge per individual session; $30 charge per group session.

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, court order, or any other reason; the charge is $100 and is due prior to scheduling the appointment for the evaluation.

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 $125 and is due prior to scheduling the appointment for the evaluation.

Parent or Guardian 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 _____

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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.

Parent or Guardian Signature: _____ *Date:* _____

TYFS Staff assisting client: _____