American Comprehensive Counseling Services

Locations

Reno/Sparks Area
860 Tyler Way
Sparks, NV 89431
(775) 356-0371
Fax (775) 356-2896

Gardnerville. Minden Area
1375 Centerville Ln.
Gardnerville, Nevada 89410
(775) 883-4325
Fax (775) 883-4355

ACCS
620 E. Plumb Ln., Ste. 201
Reno, Nevada 89502
(775) 337-6644
Fax (775) 356-2896

ACCS-Fallon
165 N. Carson St.
Fallon, Nevada 89406

ACCS –Carson City
603 E. Robinson
Carson City, Nevada 89706
(775) 883-4325
Fax(775) 883-4355

Phone: (775) 356-0371
Fax: (775) 356-2896
Toll Free: (877) 317-8064
Email: wldimitroff@hotmail.com

"Committed To Excellence In Psychotherapy"

GENERAL INFORMATION PARENTING CLASSES

	Time and Place:
Parenting Class:	12:00-7:30pm Saturday at 860 Tyler Way Sparks, NV 89431 3rd Saturday of each month 603 E. Robinson St. (Carson) (By appointment only)
Instructor:	**JoAnne Hainline, M.A., MFT**

Attendance: YOU MUST CONFIRM YOUR ATTENDANCE

All Classes: Clients must complete all intake forms before joining the group sessions. Attendance of one session is required. If you miss your session, you will be dropped from the class. You will only be allowed re-admittance upon the instructors and courts approval.

Fees:

All Classes: The class fee is $50.00(individual) and $100(couple) per session unless other arrangements are made with the office manager. We do have a sliding scale fee available. For your convenience we accept MasterCard, Visa, American Express and ATM cards.

Payment:

All Classes: A $30 deposit fee is due upon enrollment. Your fee is **due at each session**, including absences **unless prior arrangements** are made with the office manager. Receipts will be issued upon request for all payments made in class. Advance payments may be made at any time. If you have any problems during your program, please contact the office staff. Please bring your own lunch and snacks. Lunch break of 30 minutes is scheduled.

Parenting Intake Information Sheet

Black or blue ink only.

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully or ask your therapist for clarification if you do not understand an item.

Full Name: ____ Today's Date: ________________
First *Middle* *Last*

Address: ____
City State Zip

Telephone(s): ___________________ ____________________________________
Home Work

Age: _______ Birth Date: ___________________ Marital Status: M _________ S_____________ D_____________

Separated _____________ If separated how long: ____

Social Security #: ____________________________ Drivers License #: ____________________________

Name of Court if applicable: ________________________ Judge: ___________________________________

Court Case Number: ________________ Date of required completion: ________________________

Name of P.O. if applicable: ____

List the members of your family and all others in your home:

Name(s) Age/Birth Date __ Relationship Occupation_______

____

____

____

____

____

Do you have children not currently living with you? Yes ___ No____ If so how many? _____

Please provide names and ages of the children: ____

How many times have you been married? ______ Level of education completed: ____________________

Who suggested you contact me? ____

Employment Background

Employed: Yes _____ No _________ Place of Employment _____________________________________

If unemployed give reason: ____

How long have you been employed? _____________ Occupation: _________________________________

Employer's address: ____

Alcohol and Drug Background

Have you ever used an illegal drug? Yes _____ No ____ What type? ___________________________
Do you drink? Yes ____ No ____ If so what do you drink? _____________________________________

At what age did you first begin drinking? ________ Using drugs ________

How frequently do you drink or use drugs? Daily _____ Weekly ____ Monthly _____

Are you currently using? Yes ___ No ____ How frequently? Daily _____ Weekly ____ Monthly _____

Have you ever been treated for an alcohol or drug problem? Yes ____ No____

Medical History

When did a physician last examine you? ____

List any major health problems for which you currently receive treatment: ___________________________
____

List any medications you are now taking: ____
____

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes ___ No ___
If you have, please explain: ____

Please circle any of the following symptoms or difficulties, which pertain to you.

Nervousness	Unhappiness	Inferiority feelings	Friends
Depression	Sleep	Concentration	Anger
Fears	Stress	Education	Self-control
Shyness	Work	Career choices	Insomnia
Sexual problems	Relaxation	Health Problems	Making decisions
Suicidal thoughts	Headaches	Temper	Loneliness
Separation	Tiredness	Nightmares	Bowel troubles
Divorce	Legal matters	Marriage	Being a parent
Finances	Memory	Children	My thoughts
Drug use	Ambition	Appetite	Violence
Alcohol use	Energy	Stomach Trouble	

Program Guidelines

1. Everyone must participate in the class. This includes class discussions, workbook exercises, and the completion of homework assignments.

2. No alcohol or drugs can be used 1 day prior to class. If it appears that an individual is under the influence of alcohol or drugs that person will be dismissed from the Program and a recommendation will be made for an alcohol and drug assessment.

3. All court ordered weekly sessions must be completed within the completion time allotted by the court. If excessive absences are incurred that person will be suspended.

4. No smoking will be allowed in the group sessions.

5. Respect your fellow group member's privacy. Personal information regarding other group members must remain confidential.

6. Respectful language must be utilized during all class discussions. Any display of aggression, name calling, victim blaming or violence while enrolled in this Program shall be considered grounds for dismissal.

7. I understand that violation of any of the above agreements can lead to termination and notification to the referring agency.

I ____ agree to the above Program Guidelines.

Date: ______________________________

Confidentiality

I place a high value on the confidentiality of the information that my clients share with me. This sheet was prepared to clarify my legal and ethical responsibilities regarding this important issue.

Personal information that you share with me may be entered into my records in written form. This information will be kept strictly confidential, however there are some exceptions.

1. Threats to harm your self or others
2. Abusing or neglecting children
3. Abusing the elderly
4. Subpoena of records
5. Release of information allowing disclosure of information

I have read and understand the confidentiality statement and agree to it.

____ ____________________
Signature Date

____ ____________________
Signature (print name) Date

Payment Agreement

American Comprehensive Counseling Services

As part of the program I agree to pay $ ______________________per session/program.

I agree to pay for all sessions I attended at the above rate of pay. I will be allowed ____absences of my choosing, which I will also pay for, over the duration I am required to attend.

If I miss three sessions in a row or have exceeded my allowed number of absences I will be suspended immediately and notification of this suspension will be sent to the proper authorities.

If I change the location of my groups or am suspended, I must have all payments current before my paperwork will be forwarded to the new facilitator or returning to group.

If I pay by check and that check is returned I must pay a $25.00 fee and all further payments to the program must be in cash or money order.

Suspension from the program for any reason will result in notification of the appropriate authorities.

I understand and agree that if my account must be referred to any third party for collections, I will be responsible for any and all costs related to the collection action, including, but not limited to, collection agency percentage fees, court costs and reasonable attorney fees.

______________________________________ ______________________

Signature Date

____

Name, Typed or Legibly Printed

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ___________________________________, authorize American Comprehensive Counseling Service
and representatives to: _x__ (send) _x__ (receive) the following _x__ (to) _x__ (from)
the following agencies or people:

____
Name   Address   City   State   Zip Phone

____
Name   Address   City   State   Zip Phone

____
Name   Address   City   State   Zip Phone

- ( ) Academic Testing Results
- ( ) Behavior Programs
- ( ) Case Notes
- ( ) Intelligence Testing Results
- ( ) Medical Reports
- ( ) Personality Profiles
- ( ) Progress Reports
- ( ) Psychological Testing Results
- ( ) Service Plans
- ( ) Summary Reports
- ( ) Vocational Testing Results
- ( ) Entire Record
- ( ) Other (specify) ___________
- ( ) Psychological Reports

The above information will be used for the following purposes:

- ( ) Planning Appropriate Treatment or Program
- ( ) Continuing Appropriate Treatment or Program
- ( ) Determining Eligibility for Benefits or Program
- ( ) Case Review
- ( ) Updating Files
- ( ) Other (specify)

____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client ____ Date___________
Signature of Parent/Guardian_________________________________ Date ___________
Signature of Witness ____ Date ___________
(if client is unable to sign)
Signature of Person Informing _________________________________ Date___________

“Disclosure of Client information in a manner not authorized by 42 CFR Part 2 and 45 CFR Parts 160-165, is a federal criminal offense. Further disclosure to any person or party for which consent has not been provided to client is further prohibited by Law and Statute.”