PeaceWay Counseling and Mediation Services, Inc.

Client Name:____
First Middle Last

Date of Birth:__________ Social Security:__________ __________

Marital Status:__________ Male 0 Female 0 Ethnicity: __________

Street Address:____
City State Zip

Home Phone:____________________ Cell Phone:____________________

Employer:____________________ Work Phone:____________________

Email Address:____

If Client is a minor, do you have legal custody? Yes 0 No 0 If divorced, has either parent had their parental rights terminated? Yes 0 No 0

Legal Guardian's Name:____________________ Relationship to Client:__________

Legal Guardian's Social Security Number:________________ Guardian's Date of Birth:__________

Is Client a full time student? Yes 0 No 0 Name of school:____________________

Emergency Contact:__________________________ Phone:__________________

Emergency Contact Address:____

Relationship to Client:__________________________

Insurance Company:__________________ Address:______________________

Phone:______________________ Policy holder's name:__________________

Policy Number:____________________ Group Number:____________________

Policy Holder's Social Security Number:__________________

Policy Holder's Date of Birth:__________

I request that payment and benefits be made on my behalf to PeaceWay Counseling & Mediation Services, Inc. for any services furnished to me by its physicians or providers. I understand that my signature also authorizes release, if necessary, of any medical, psychiatric and substance abuse information contained in my records to my insurance or its assignees. I request and authorize treatment at PeaceWay Counseling & Mediation Services, Inc. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance.

________________________________ __________________
Signature of Client or Legal Guardian (Relationship) Date

Who referred you to our office?____

Have you ever received counseling before? Yes 0 No 0 If yes, where?__________________________

Are you involved in any legal actions or lawsuits? Yes 0 No 0

Attorney's Name:______________________ Type of Suit:_________________________

Briefly describe your reason for wanting counseling:_______________________________

____

____

____

____

____

List any medications that you are taking:____

____

Client's Signature:_________________________________ Date:______________
(Parent/Legal Guardian, if client is a minor)

____
PCMS Staff Witnessing Print Full Name (Legal Name)

____
PCMS Staff Witnessing Signature of Full Name Date

201809251607

Military OneSource Program Participant Statement of Understanding

You have been referred by Military OneSource for an assessment and/or short-term, non-medical counseling services which are provided at no cost to you to address a specific non-medical issue within twelve (12) sessions.

Please be on time for your appointments and provide at least 24 hour notice if you are unable to keep an appointment.

Confidentiality

Information you provide to the Military OneSource counselor will be kept confidential, except to meet legal obligations or to prevent harm to self or others. Legal obligations include requirement of law the Department of Defense or military regulations. Harm to self or others includes suicidal thought or intent, a desire to harm oneself, domestic abuse, child abuse or neglect, violence against any person, including sexual assault involving service members, and any present or future illegal activity.

Military OneSource counselors are not authorized to receive a domestic abuse or sexual assault restricted report. If the person receiving counseling requests restricted reporting pursuant to domestic abuse or sexual assault, the Military OneSource counselor will transfer the person to a specified individual who is authorized to receive a restricted report in the respective military service branch according to Department of Defense policy.

A written and electronic record (date, time, nature of meeting) of your contact with the Military OneSource counselor will be maintained in a secure manner. Access to your record will not be given to anyone outside of Military OneSource, except as previously stated. Record audits may be conducted by the Department of Defense for the purpose of program administration and quality assurance and those audits will not include access to any of your Personally Identifiable Information (PII) or Protected Health Information (PHI). To access your file, contact Military OneSource.

Counseling for Children

- **Children under age 13 may not receive individual counseling through Military OneSource. However, these children can be included in family counseling.**
- **Children age 13-17 must have signed parental/guardian consent to receive individual counseling, and the parent or guardian must accompany the child to the initial appointment for the purpose of establishing this consent and any related required permissions.**

There is no cost to you for counseling services through Military OneSource. However, if your issue of concern is beyond the scope of counseling provided through Military OneSource, the counselor will refer you to the appropriate healthcare resources, which could require use of your military health benefits (TRICARE) or health insurance. It would be your responsibility to verify that your health benefits/insurance will cover the costs of such treatment or resources.

I hereby acknowledge that I have read this statement of understanding and understand its contents.

____

Signature of Client *Date*

____

Signature of Parent or Guardian (if client is a minor) *Date*

____

Signature of Counselor or Witness *Date*

____

Signature of Additional Participant *Date*

____

Signature of Additional Participant *Date*

____

Signature of Additional Participant *Date*

Military One Source Case Activity and Billing Form

Instructions: Please use CAPITAL letters. **ALL** information is required to ensure payment. Submit within 15 days of the Date of Service. Keep a copy for your records.

Statement of Understanding (SOU) Signed: O Yes O No (All participants must sign the SOU)

Authorized Participant Information: *Last Name* *First Name* *MI*

Participant's Address: *Street Address* *City*

State *ZIP Code* **Date of Birth** (mm/dd/yy) / / **Participant Home Phone** - -

Participant Gender: O Female O Male **No Session/ Missed Appt.:** O Yes O No ('Yes' if Closing Case w/o session)

Billing Information: Date of Service (mm/dd/yy) / /

Mode of Delivery:
O Face-to-Face O Video
O Telephonic O Online

Authorization Number

Counselor: *Last Name* *First Name* *MI*

Counselor Billing Address:

Street *City*

State *ZIP Code* **Tax ID Number or SSN:** **NPI Number:**

Counselor's Phone: - -

Counselor's Signature: ____________________ **Date:** __________

Total Sessions Billed: __________

Number of Sessions Used at Case Closing: __________

Assessed Problem (Choose 1 Problem/Issue):

O Z63.0 Relational Distress with Intimate Partner
O Z71.9 Other Counseling or Consultation
O Z60.0 Phase of Life Problem
O Z62.820 Parent-Child Relational Problem
O Z56.9 Problem Related to Employment
O Z63.5 Disrupt. of Family by Separation/Divorce
O Z63.4 Uncomplicated Bereavement
O Z56.82 Problem Related to Current Military Deployment Status
O Z62.898 Child Affected by Parental Rel. Distress
O Z91.82 Personal History of Military Deployment
O Z59.9 Housing or Economic Problem
O Z91.411 History of Partner Psychological Abuse
O Z91.412 History of Spouse or Partner Neglect
O T74.11 Physical Abuse by Nonpartner (confirmed)
O T76.11 Physical Abuse by Nonpartner (suspected)
O T74.31 Psych. Abuse by Nonpartner (confirmed)
O T76.31 Psych. Abuse by Nonpartner (suspected)
O T74.21 Sexual Abuse by Nonpartner (confirmed)
O T76.21 Sexual Abuse by Nonpartner (Suspected)
O Z91.410 History of Partner Violence, Physical

O Z91.410 Hist. of Partner Violence, Sexual
O Z62.810 Hist. of Physical Abuse as Child
O Z62.810 Hist. of Sexual Abuse as a Child
O Z62.811 Hist. of Psych. Abuse as a Child
O Z72.9 Problem Related to Lifestyle
O Z63.8 High Emotional Level Within Fam.
O Z65.8 Problem Related to Psychosocial
O Z59.9 Prob. Related to Social Environ
O Z91.49 History of Psychological Trauma
O Z65.4 Victim of Crime
O Z60.3 Acculturation Difficulty
O Z60.4 Social Exclusion or Rejection
O Z60.5 Target of (perceived) Discrimination or Persecution
O Z62.891 Sibling Relational Problem
O Z56.8 Religious or Spiritual Problem
O Z65.5 Exposure to Disaster or War
O Z72.810 Child/Adolescent Antisocial Beh.
O Z60.2 Problem Related to Living Alone
O Z91.89 Other Personal Risk Factors
O Z62.29 Upbringing Away From Parents

O Z59.6 Low Income
O R41.83 Borderline Intellectual Functioning
O Z59.0 Homelessness
O Z59.2 Discord w/ Neighbor or Landlord
O E66.9 Overweight or Obesity
O Z65.2 Problem Related to Release From Prison
O Z65.3 Prob. Related to Legal Circumstanc
O Z91.5 Personal History of Self-Harm
O Z64.0 Problem w/ Unwanted Pregnancy
O Z64.1 Problem Related to Multiparity
O Z55.9 Academic or Education Problem
O Z59.1 Inadequate Housing
O Z59.3 Problem Living in Residential Inst.
O Z59.4 Lack of Adequate Food/ Water
O Z59.5 Extreme Poverty
O Z59.7 Insufficient Social Insurance, or Welfare Support
O Z75.3 Unavailability of Health Care Facilities
O Z75.4 Unavailability of [illegible]

Participant Last Name

First Name

Does participant have a DSM diagnoses?	O Yes O No *(If yes, refer case to medical/mental health treatment)*	
Is the issue related to deployment?	O Yes O No	
Is the issue related to reintegration?	O Yes O No	

Risk and Functional Assessment: Indicate participant's level of impairment for each Session and at Case Closing:

0= No Evidence of Impairment **1= Mild** Impairment **2= Moderate** Impairment **3= Severe** Impairment (*significant impairment*)

Item	0	1	2	3
Member's risk to self..	O0	O1	O2	O3
Member's risk to others....................................	O0	O1	O2	O3
Mood Disturbances (depression or mania)............	O0	O1	O2	O3
Anxiety...	O0	O1	O2	O3
Thinking / Cognition / Memory / Concentration........	O0	O1	O2	O3
Impulse / Reckless / Aggressive Behavior..............	O0	O1	O2	O3
Activities of Daily Living Problems........................	O0	O1	O2	O3
Medical / Physical Condition................................	O0	O1	O2	O3
Substance Abuse / Dependence...........................	O0	O1	O2	O3
Job / School Performance..................................	O0	O1	O2	O3
Social Functioning / Relationship / Marital / Family...	O0	O1	O2	O3

High Risk Case: O Yes O No

If High Risk = Yes: **Call 800-342-9647** and document risk in Case Summary Note

Reviewed with MOS consultant? O Yes O No

If yes, w/ whom?
(Consultant's name) ____________

Was a safety plan developed? O Yes O No

Counseling Goals: (At least **one goal** is **required**)

Goal	Status
1.	O Met O Partially Met O Not Met O No Change
2.	O Met O Partially Met O Not Met O No Change
3.	O Met O Partially Met O Not Met O No Change

Mental Health Treatment History Assessed	O Yes O No
Substance Abuse Treatment History Assessed	O Yes O No
Strength, Skills, and Interests Assessed	O Yes O No
Supports Assessed	O Yes O No
Document critical assessment items in Case Summary Note	

(Call If Current)	None/Denies	Current (<1yr)	History
Domestic Violence	O	O	O
Child Abuse/Neglect	O	O	O
Sexual Assault	O	O	O
Sexual Abuse (of minor)	O	O	O

Was a legally required report filed (*CPS, DHS, PD, etc.*)? **O Yes O No**

If Yes (Required): By Whom:____________ When:__________ Where:__________

Case Summary Note: **A.** Participant Presentation **B.** Steps Taken **C.** Response (Please include critical events or issues)

First and Last Session: Participant's Response To, "How would you rate the severity of your problem?" *(Both questions should be related to the initial Assessed Problem)*	O Low O Moderate O Severe O Very Severe O Do Not Know O Did Not Respond O Provider Deemed Question Inappropriate
Last Session: Participant's Response To, "How is your ability to address the issue as compared to the start of counseling?"	O Improved O Same O Lower O Did Not Respond O Provider Deemed Question Inappropriate O NA

Case Closing/Final Session *(Must complete upon Case Closing/Final Session or after 30 days of no contact)*

Closing Reason:
- O Participant's case successfully resolved
- O Participant withdrew/dropped out before the completion of services
- O Participant discontinued for other reasons
- O Out of Scope- Escalated to Crisis
- O Out of Scope- Non Crisis

Reasons Deemed Out of Scope (If Indicated)
- O Risk to Self O Risk to Others
- O Currently Receiving Mental Health Tx.
- O Currently Prescribed Psych. Medication
- O Diagnosed w/ Mental Health Condition
- O Fitness for Duty or Court Ordered
- O Psych. Hospitalization O Illegal Activity
- O Domestic Abuse O Child Abuse/Neglect

Case Disposition:
- O No Referral made to other resources
- O Referral for other resources accepted
- O Referral for other resources declined
- O Did Not Keep Initial Appointment
- O Discontinued Counseling

Overall Status of Goals:
- O Goals Met
- O Partially Met Goals
- O Goals Not Met

Submit Electronically via ProviderConnect or Fax to 877-762-1356

Referral Type (check all that apply)
- O No referral beyond MOS
- O TRICARE
- O Military Treatment Facility
- O Victim Advocate
- O Sexual Assault Response Coordinator
- O Family Advocacy Program
- O Other Medical
- O Other Substance Abuse
- O Other Mental Health
- O Community Resource
- O Red Cross

This form is due within 30

Military OneSource

Military OneSource
Case Activity Form
Participant Addendum (CAF-PA)

Instructions: For all couples and/or family cases, complete this Participant Addendum for every additional participant who attended the session. Submit along with the Case Activity Form (CAF).

***Authorization Number** ________________

***Date of Service** (mm/dd/yy) __ __ / __ __ / __ __

Additional Participant # 1

Information:

***Relationship to Participant:**____________________ ***Gender:** ○ Male ○ Female

***Age** __ __

Missed Appt./Not Present: ○ Yes ○ No

***Statement of Understanding (SOU) Signed:** ○ Yes ○ No (SOU must be signed by all participants)

Additional Participant # 2

Information:

***Relationship to Participant:**____________________ ***Gender:** ○ Male ○ Female

***Age** __ __

Missed Appt./Not Present: ○ Yes ○ No

***Statement of Understanding (SOU) Signed:** ○ Yes ○ No (SOU must be signed by all participants)

This form is due within 30 days of the date of service.

Please Fax to 877-762-1356 or Submit Electronically via ProviderConnect