SOME THINGS YOU SHOULD KNOW ABOUT COUNSELING ♥ INFORMED CONSENT

This Informed Consent and Release of Liability is intended to provide you with important information regarding the practices, policies, and procedures; and to clarify the terms of the professional relationship. Any questions or concerns regarding the contents of this Agreement should be discussed prior to signing it.

CONFIDENTIALITY

Of course, all of our work together – our conversations, your records, and any information that you give us – is protected by something called privilege. That means that the law protects you from having information about you given to anyone without your awareness and permission. Our office respects your privacy, and we intend to honor your privilege. However, there are limits to your privilege and legal exceptions that you should understand before we start.

If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the person to give them the opportunity to protect you or the other person. If we have cause to believe that you are abusing children or the elderly or disabled people, we are required by law to notify the authorities. Also, if you become involved in any lawsuit in which you claim mental health is an issue—for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering—then the court or the lawyers may insist upon, and may obtain your information from us.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance & managed care information is often stored in national computer databases. If we find ourselves in a dispute with you over billing, our office may provide the collection company with information necessary to collect any outstanding balance.

SIDE EFFECTS AND OTHER POTENTIAL UNPLEASANTNESS

You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you will become somewhat depressed. This process is intended to alleviate problems, but sometimes, especially at first, and as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you try new ways of doing things that at first may make you feel awkward or uncomfortable. You will always be free to move at your own pace; however, we will challenge you and your old ways of thinking and doing, but we cannot offer any promise about the results you will experience. Your outcome will depend upon many things.

Our office specializes in general adult, child & adolescent, and couple's counseling. If we believe that your problems require knowledge that we do not have, we may refer you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act. At the very beginning, we will create a treatment plan with you. We will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Mindfully, we will review that plan to see if it needs to be updated.

OUR OFFICE POLICIES AND FEE & PAYMENT AGREEMENT

We schedule appointments and payment transactions at the beginning of the session; to avoid the interruption of thorough processes at the end of the session. Counseling sessions usually last 45-50 minutes, and we must end each session promptly. We can accept cash, checks, or credit cards for your payment. **Our office has a NO CANCELLATION POLICY and charges $80 for missed/no-shows or if you are late, including missed rescheduled appointments. Scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for re-scheduling or canceling an appointment. We will however offer a make-up session as a courtesy for paid missed sessions. It Does Not Replace already scheduled appointment. Your insurance will not pay for missed sessions; these charges will be entirely your responsibility. Our office charges a $35 fee for returned checks and a $3.00 fee on all credit card transactions.** Our collaboration gives you the tools to have a thriving and fulfilled life. *It is the price one contributes towards one's evolving change.*

Our office is happy to accept insurance assignment and to file insurance claims to receive payment for our time if we have a contract with your insurance or third party payer. In that case, our office will file claims according to the contract terms with your insurance. Your co-pay is due at the beginning of your visit. If there is a problem collecting payment from your insurance or managed care company for the balance, you remain responsible for payment of the full fee for each visit. If we have not received payment from your insurance or other third party payer 45 days of any counseling session, we will bill you directly for past and for ongoing visits at the customary fee noted above. If your carrier does not pay, you will be responsible and your failure to pay or your inability to pay may necessitate that we refer you to another provider.

Our telephone is answered twenty-four hours a day by a digital answering system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost. We do not check office messages after 5:00 P.M. on weekdays, or routinely on weekends. If you have an emergency after 5:00 P.M. or on a weekend, call 911, or go to an emergency room.

When we are out of the office for several days, the messages you leave may be answered by another counselor. We will probably not have discussed your case with that person, but he or she will make every effort to be helpful to you in our absence. If we have another professional taking calls while we are away, please find comfort that we have confidence that that professional is properly trained to be helpful to you. To the extent possible, we will keep you informed about when we are away from the office and when we will return.

ACKNOWLEDGEMENT AND RELEASE OF LIABILITY

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this agreement and consent to participate in counseling and coaching.

Moreover, in consideration of the benefits to be derived from the counseling process, the receipt whereof is hereby acknowledged. You hereby indemnify and hold harmless, release, remise and forever discharge and covenant not to sue or hold legally liable; the owner and Program Director of BN Counseling, LLC, (Brian Nandy), MA, LPC, the counselors and coaches, the supervisors, or the staff from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.

I, (client's name) _____, have read this Informed Consent and Release of Liability document. I understand it and agree to comply to the terms described.

Signature. *Printed signature functions as agreement to terms & conditions.* Date Signed

HIPPA PRIVACY NOTICE | Notice of Policies and Practices to Protect the Privacy of Your Health Information

We at BNCounseling are committed to protecting your privacy and your medical records. However, we may have to use and disclose medical information as outlined below:

♥**For the purpose of providing medical treatment and psychotherapy:** Information may be shared with other providers outside this office if they are involved in your treatment.

♥**For the purpose of payment.** We may disclose medical information about you for billing and collection. This may involve an insurance company, a family member, a collection agency, or any third party that may be involved in payment for your care.

♥**For appointment reminders.** We may call you, text you, speak to you or leave a message with someone or an answering machine regarding your upcoming appointment.

♥**For authorization of initial treatment or continuation of treatment.** We may disclose medical information to insurance companies, HMOs or managed care companies in order to obtain approval for treatment plans.

♥**As required by law.** We will disclose medical information about you if required by law.

♥**To avert a serious threat to health or safety.** We may disclose medical information about you to prevent a serious threat to your health and safety of the public or another person.

♥**Worker's Compensation and disability.** We may release medical information about you to Workers' Compensation programs, disability insurers, or Social Security Administration. In certain instances, such information may be released to your employer.

♥**Public health risks.** We may disclose medical information about you in cases of child abuse or neglect, adult abuse or neglect, domestic violence, and any potential risk.

♥**Health oversight activities.** We may disclose medication information to a health oversight agency for activities authorized by law such as audit, investigations, inspections and licensure.

♥**Legal matters.** We may disclose medication information about you to attorneys, courts or other agencies in response to a court order, warrant, summons, subpoena, discovery or request, or to assist in an investigation.

YOUR RIGHTS REGARDING MEDICATION INFORMATION ABOUT YOU

♥**Right to inspect and copy.** You have the right to inspect and request a copy of your medical record as well as your billing record. You must submit a written request and pay for the cost of copying your records.

♥**Right to amend.** If you feel that the medical information contained in your record is incorrect or incomplete, you have the right to ask to amend the information. You must submit a written request and provide a reason for your request.

♥**Right to an accounting of disclosures.** You have the right to request in writing a list of the disclosures made of medical information I use or disclose about you.

♥**Right to request restrictions.** You have the right to request in writing a restriction or limitation on medical information use or disclose about you.

♥**Right to request confidential communication.** You have the right to request that communication with you about your medical matters in a certain way or at a certain location.

♥**Right to a paper copy of this notice.** I will provide you with a copy of this notice upon your request.

Your signature and date below acknowledges that you have been provided with this document regarding policies and practices concerning your protected health information (PHI). Your signature below also gives general consent for use or disclosure of your protected health information (PHI) for treatment, payment, and health care operations purposes. Your signature also allows us to leave voicemail messages, text messages at the telephone numbers you provide regarding confirming/changing appointments, questions about insurance, etc.

Print Patient Name	Patient Signature	Date
If patient under age-18 or Unable to consent. PRINT parent[s]name/ Sole Legal Guardian	If patient under age-18 or Unable to consent. SIGNATURE of parent[s]name/ Sole Legal Guardian	Date
If Joint Custody of Minor PRINT name of Other/Parent/Other Legal Guardian	If Joint Custody of Minor SIGNATURE of Other/Parent/Other Legal Guardian	Date

REGISTRATION FORM

Client Name:	Date of Birth:	Age:
Partner/ Spouses' Name:	Partner/ Spouses' Date of Birth:	Age:
Child's Name:	Child's Date of Birth:	Age:
Child's Name:	Child's Date of Birth:	Age:

Client Address:	City:	Zip:

Home Phone:	Cell Phone:	Work phone:
Email Address:		
Gender: □M □F □Trans_____ □Other:	**Ethnicity**: □AA □White □Latino □Asian □Others:	**Marital Status:** S Domestic Partner M W D

Social Security No.:	Place of Employment
Partner /Spouse Name:	Place of Employment
Psychiatrist Name & Tel Number:	Primary care physician Name & Tel Number:
Referred By:	May we thank this person for the referral? □ Yes □ No
Emergency Contact: [Name & Telephone no.]	

Insurance Information

Insurance Company:	Insurance ID #:
Subscriber's Name:	Date of Birth:
Social Security Number:	Address (if different from above):

Release of Information & Assignment of Benefits

I authorize to provide necessary clinical information requested by insurance companies to pay BNCounseling directly. I understand that I am responsible for any **CHARGES OR SERVICES NOT COVERED BY MY INSURANCE COMPANY**, including co-pays and deductibles.

NO CANCELLATION PAYMENT POLICY

Payment is kindly due at the time of service. **Our office has a NO CANCELLATION POLICY and charges $80 for missed/no-shows or if you are late, including missed rescheduled appointments. Scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for re-scheduling or canceling an appointment. We will however offer a make-up session as a courtesy for paid missed sessions. It Does Not Replace already scheduled appointment. Your insurance will not pay for missed sessions; these charges will be entirely your responsibility. Our office charges a $35 fee for returned checks and a $3.00 fee on all credit card transactions.** Our collaboration is purposeful and significant. It gives you the tools and understanding necessary to have a thriving and fulfilled life. *It is the price whom one contributes towards one's evolving change….and we are both worth it.*

Please make all checks payable to **BN COUNSELING, LLC** 95 W 13th St, 2nd Floor, Bayonne, NJ 07002

Signature: *Printed signature functions as agreement to terms & conditions.*	**Date:**

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc.
Include prescription, over-the-counter, herbal, vitamin, and diet supplement products.
Also list any medicine you take only on occasion

Patient Name:	DOB:

Medication Name	Dose	How do you take it?	How often do you take it?	Reason for taking	Date Started/ Changed	Healthcare Provider
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				
		□Mouth □Inject				

Allergies (please describe reaction)		

Doctor's Name	Phone Number	Type of Practitioner / Reason for Seeing

PAYMENT AUTHORIZATION FORM

CREDIT CARD – ACH

{Our relationship with money and time reflects how we value ourselves and others}

Thank you for choosing us as your wellness provider. While your wellness is our priority, we still must charge for missed appointments. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have about your coverage. The following questions may serve as a guide in helping you obtain pertinent information regarding eligibility and benefits.

KINDLY TAKE TIME TO READ EACH STATEMENT AND INITIAL THAT YOU ACKNOWLEDGE AND AGREE. THANK YOU.	INITIAL
At BN Counseling we **respectfully request for your credit card information to 'hold' your reserved appointment**, similar to when reservation agents ask for a credit card to hold a hotel room or a table at a restaurant. This helps reduce no-shows, ensures the appointment is paid for cancellations & missed appointments	
MISSED APPOINTMENTS. We understand that on rare occasions, true emergencies may arise. Our policy is to charge **$80.00 for each missed/no-show therapy session including missed rescheduled appointments that are** not rescheduled 48-hours in advance. Insurance health plans do not pay for missed appointments; these charges will be entirely your responsibility.	
Patients have the option of providing a signed check, which we only deposit for no-shows.	
Our office charges a $35 fee for any check returned for any reason and a **$3.00 fee on all credit card transactions.** Payments with a Flexible Spending Card is exempted from the fee.	

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

PLEASE COMPLETE THE INFORMATION BELOW

I _____ (full name) authorize BN Counseling, LLC to charge my credit card as payment indicated below for scheduled appointments for payment of my sessions/co-payment/co-insurance/deductible. These charges include full payments for missed appointment unless otherwise negotiated.

Billing Address: _____City_____ State_____ Zip _____

Phone#: _____Email: _____

CREDIT CARD: ☐Visa ☐Master ☐Amex ☐Discover ☐Other:

Cardholder Name: _____ Account Number: _____

Exp. Date: _____ CVV (AMEX 4 digit number front of card)_____

SIGNATURE _____ **DATE** _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify BN Counseling, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that BN Counseling, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $30 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

NO CANCELLATION PAYMENT POLICY | INSURANCE o MISSED APPOINTMENT FEES

{Our relationship with money and time reflects how we value ourselves and others}

Thank you for choosing us as your wellness provider. While your wellness is our priority, we still must cover this often uncomfortable topic about payments & missed appointments.

Kindly take time to read each statement and initial that you acknowledge and agree. Thank you.	Initial
MISSED APPOINTMENTS. Rescheduling is preferred over cancellation. Weekly standing appointments are what we call **"your time"** meaning that we will honor **"your time"** in expectation of rendering you professional & courteous service for your scheduled appointment. Scheduling of an appointment involves the **reservation** of time specifically for you, a minimum of **48 hours** notice is required for re-scheduling an appointment. **If you miss or do not show up at "your time," please be aware that you will be charged a cancellation fee of $80.00 for each missed/no-show therapy session including missed rescheduled appointments.** Insurance health plans do not pay for missed appointments; these charges will be entirely your responsibility. We understand that on rare occasions, true emergencies may arise. We will do our absolute best to assist with rescheduling paid missed sessions due to true emergencies. Rescheduling appointments are highly dependent on availability that mutually converges for the client and counselor. We will however offer only 2 make-up opportunities as a courtesy for paid missed sessions. **Rescheduled sessions DO NOT replace already scheduled weekly appointments.**	
NON-COVERED SERVICES. Some (perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by insurers, such as relationship counseling or trauma related techniques [EMDR]. You must pay for these services in full at the time of visit. In addition to your weekly appointments, please note that we charge an hourly rate for other professional/legal services you may need such as report writing, mental health assessments, telephone conversations longer than 15 minutes, teleconferences with other professionals you have authorized, preparation of records and/or treatment summaries, etc.	
NONPAYMENT. Please bear in mind that should your account remain unpaid in 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.	
INSURANCE. We participate with some insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.	
CO-PAYMENTS AND DEDUCTIBLES. All co-payments & deductibles must be paid at the time of service. Failure to collect co-payments and deductibles from patients can be considered fraud. Please uphold the law with payments.	
PROOF OF INSURANCE. All patients must complete our registration form before being seeing. Please provide a copy of your driver's license and current proof of insurance. You may be responsible for the claim balance of incorrect information.	
CLAIMS SUBMISSION. We will submit your claims & assist to help get your claims paid. The balance of your claim is your responsibility whether or not your insurance company pays your claim.	
COVERAGE CHANGES. If your insurance changes, please notify us before your next visit. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.	
SELF-PAYMENT Periodically, fees will be increased; no more than once per year with the courtesy of advanced notice where you are encouraged to express any financial concerns with your therapist.	
COMMITMENT TO THE WORK. ***Our collaboration is purposeful and significant; because it bridges the gap between your vision and evolution towards a flourishing and meaningful life.*** An appreciable change occurs when your appointments are consistently scheduled and regularly attended. Consecutive missed appointments can be offered to clients who could benefit from a session. Unlike other medical professions, psychotherapy isn't one that can be rapidly scheduled with a short waiting period. *The cost of this professional investment is driven by the creation of value of our empowered psychological properties. It is the price whom one contributes towards one's evolving change….and we are both worth it.*	
RETURNED CHECK FEE. Our office charges a $35 fee for any check returned for any reason.	
CREDIT CARD FEE Our office charges a $3.00 fee on all credit card transactions. Payments with a Flexible Spending Card is exempted from the fee.	

Our practice is committed to providing you with the best treatment. Our fees are representative of the usual & customary charges for our area. Thank you for understanding our payment policy. Let us know if you have questions or concerns.

- *I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service, are my responsibility.*
- *I authorize BN Counseling, LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to BN Counseling, LLC*

Signature of patient or responsible party	Printed Name	Date

CLIENT INTAKE FORM

❤Name:	DOB:
Are you currently receiving psychiatric services, professional counseling elsewhere? If Yes, therapist's name or purpose:	□ Yes □ No
Have you had previous psychotherapy? If Yes, Previous therapist's name or purpose:	□ Yes □ No
Are you **currently** taking prescribed psychiatric medication? If Yes, please list:	□ Yes □ No
Have you been **previously** prescribed psychiatric medication? If Yes, please list:	□ Yes □ No

HEALTH AND SOCIAL INFORMATION	
How is your physical health at present? □Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good	
Please list any persistent physical symptoms, allergies or health concerns:	
How many times per week do you exercise?	Approximately how long each time?
Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting Have you had significant weight change in the last 2 months? □ No □ Yes: Increase/Decrease How Much:	
Problems with sleep? □Yes □No If yes, □Sleeping too little □Sleeping too much □Poor quality sleep □Disturbing dreams	
Past or present regular use alcohol? If Yes, what's the quantity/frequency:	□ Yes □ No
Past or present regular use cigarettes? If Yes, what's the quantity/frequency:	□ Yes □ No
Past or present regular recreational drug use? If Yes, what's the quantity/frequency:	□ Yes □ No
Suicidal thoughts recently?□None □Passive □Active **If Active**: Plan:□N □Y Intent:□N □Y Means:□N □Y	Homicidal ideation: □None □Passive □Active If Active: Plan:□N □Y Intent:□N □Y Means:□N □Y
Are you currently in a romantic relationship? □ No □ Yes If yes, how long have you been in this relationship? _____ On a scale of 1-10, how would you rate the quality of your current relationship? _____	
In the last year, have you experienced any significant life changes or stressors:	

OCCUPATIONAL INFORMATION:	
Are you currently employed? □ No □ Yes	If yes, what do you do?
If yes, are you happy at your current position? □ No □ Yes	
Please list any work-related stressors, if any:	

RELIGIOUS/SPIRITUAL INFORMATION:	
Do you consider yourself to be religious? □ No □ Yes	If yes, what is your faith?
If no, do you consider yourself to be spiritual? □ No □ Yes	

HAVE YOU EVER EXPERIENCED:

- □ Extreme depressed mood
- □ Wild Mood Swings
- □ Rapid Speech
- □ Extreme Anxiety
- □ Panic Attacks
- □ Phobias
- □ Sleep Disturbances
- □ Hallucinations
- □ Unexplained losses of time
- □ Unexplained memory lapses
- □ Alcohol/Substance Abuse
- □ Frequent Body Complaints
- □ Eating Disorder
- □ Body Image Problems
- □ Repetitive Thoughts (e.g.,Obsessions)
- □ Repetitive Behaviors (e.g., Frequent
- □ Checking, Hand-Washing)
- □ Homicidal Thoughts
- □ Suicide Attempt

FAMILY MENTAL HEALTH HISTORY: Has anyone in your family experienced difficulties with the following?

	If Yes, Who?	If Yes, Who?
□Depression:		□Bipolar Disorder
□Anxiety Disorders:		□Panic Attacks:
□Schizophrenia		□Alcohol/Substance Abuse
□Eating Disorders:		□Learning Disabilities:
□Trauma History:		□Suicide Attempts:

What are your Counseling goals ?

What are effective coping strategies that you've ?

Signature. *Printed signature functions as agreement to the authenticity of the information provided.*

Date:

CLIENT INTAKE FORM

FOR OFFICE USE		
MOOD	□ Euthymic[stable/tranquil] □ Anxious □ Angry □ Depressed □ Euphoric □ Irritable □ Comments:	
APPEARANCE	□ Neat □ Disheveled □ Inappropriate □ Bizarre	
SPEECH	□ Normal □ Tangential □ Pressured □ Impoverished	
AFFECT	□ Full □ Constricted[holding back emo] □ Flat[no emotional] □ Labile[emotional & not matching issue] □ Other Comments	
ATTENTION	□ Normal □ Distracted □ Other Comments:	
BEHAVIOR/Impulse Ctrl	□ Cooperative □ Guarded □ Agitated □ Aggressive □ Withdrawn □ Other Comments:	
INSIGHT+JUDGMENT	□ Good □ Fair □ Poor Comments:	
MEMORY/CONCENTRATION	□short term intact □long term intact □distractable/ inattentive □other (describe):	
THOUGHT CONTENT **If Passive and/or Active, administer Suicide/Homicidal Assessment	Suicidal ideation: □None □Passive □Active If Active: **Plan**:□N □Y **Intent**:□N □Y **Means:**□N □Y	Homicidal ideation: □None □Passive □Active If Active: **Plan**:□N □Y **Intent**:□N □Y **Means:**□N □Y
	□Delusions □Obsessions/compulsions □Phobias □Other (describe)	

SUICIDE ASSESSMENT	
Considered suicide before?	□No □If Yes, □Passive □Active
If Yes, Ever made an attempt?	No If Yes: How and when?
Is there a specific method?	No If Yes:
💣How lethal is the stated method?	□Low □Medium □ High [*review table below*]
Duration has pt considered Suicide?	Hours Days Weeks Months
HOMICIDAL ASSESSMENT	
Considered homicide before?	□No □If Yes, □Passive □Active
Ever made an attempt?	No If Yes: How and when?
Is there a specific method?	
💣How lethal is the stated method?	□Low □Medium □ High [*review table below*]
Duration has pt. considered Homicide?	Hours Days Weeks Months

Risk Level	Details	Mental Health	Precipitating Event	Person's Disposition	Action
Low 💣	-states feeling suicidal -No suicide plan/intent -No immediate danger	-May/may not have past counseling -May/may not have mental Illness diagnoses/treatment	-Recent crisis Or string of crises.	-Primary need someone to talk -Person open to& active in dev Positive plan -has a basic support system	-Explore primary issues. -Discuss short and long term actions plans. -Contract with person to fulfil positive action plan -Contract to reach for help if suicidal return.
Moderate 💣💣	-states feeling suicidal -has plan -has available means to the plan But not readily accessible -intent not immediate	-May have family history of Suicide and/or mental illness. -May have chronic mental Illness diagnosis	-feels negative life Events have been Ongoing for years. "here & now."	-seem uncertain about prospect of future happiness/wellness. -still willing to reach for help and dev a poz plan of action	-Explore primary issue. -Discuss short & long term plans & mental health assessment -Contract positive action plan. -Contract to get help again if suicidal return.
High 💣💣💣	-feeling suicide -Plan developed -Has Intent -Means available -attempt before, suicidal long time	-likely chronic mental illness Is/not diagnosed. -Likely family history of mental illness/suicide.	-Recent crisis likely adds to ongoing Crisis/distress	-states intent to die. -Resist communicate/ alternatives. -hopeless & no fear of death. -You believe pt will harm self	-If suicide in progress, call 911 -Contract to seek psych professional.{follow up to make sure this was done} -Contract to reach for help if suicidal return.