

## Adult Program Attendance Policy

### 1. Importance of consistent attendance

It is important to attend your scheduled appointments. Poor attendance will reduce the effectiveness of therapy and impact your outcomes or goal achievement. Your frequency of therapy is directed by your physician's orders. When you are out of compliance, we will notify your physician. For Bay Area to continue to provide quality services, our therapists must be given the opportunity to work in as efficient and effective an environment as possible. Failure to provide advance notice, generally considered during business hours the day prior for early morning appointments and no less than two hours for appointments in the afternoon, of your absence prevents the staff from using that time to assist another client.

### 2. Attendance Policy and Actions Taken

- **Clients who miss 2 consecutive scheduled appointments will be removed from the schedule and discharged from therapy.** We will attempt to notify you by phone. This policy will be strictly enforced.
- **Please be early or on time.** You are scheduled for a set amount of time based on your physician's request. Typically we do not have the ability to go beyond your scheduled time so you will likely lose valuable therapy time when you are late.
- **Inactive clients will be discharged.** Based on your schedule, consecutive absences may result in your discharge from the program. A notice will be sent to you and your physician. You must return to your physician and obtain a new prescription prior to receiving a new evaluation.
- **If you have a change in medical status or hospital admission your status will be changed to inactive or you will be discharged.** For your own protection, you must obtain a release from your physician and be re-evaluated before returning to the active schedule.
- **Any discharge based on poor attendance will be reviewed before any future evaluations.**

### 3. Appreciation

We appreciate your business and will make every effort to accommodate a time that is mutually convenient. Exceptions to the policy will be considered on a case-by-case basis. If you feel that you have a situation requiring special consideration please contact the Adult Scheduler.

### 4. Signature & Agreement

I have read and understand the Attendance Policy and agree to comply.

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client/Caregiver

\_\_\_\_\_  
Date

## Adult Program Attendance Policy

### 1. Importance of consistent attendance

It is important to attend your scheduled appointments. Poor attendance will reduce the effectiveness of therapy and impact your outcomes or goal achievement. Your frequency of therapy is directed by your physician's orders. When you are out of compliance, we will notify your physician. For Bay Area to continue to provide quality services, our therapists must be given the opportunity to work in as efficient and effective an environment as possible. Failure to provide advance notice, generally considered during business hours the day prior for early morning appointments and no less than two hours for appointments in the afternoon, of your absence prevents the staff from using that time to assist another client.

### 2. Attendance Policy and Actions Taken

- **Clients who miss 2 consecutive scheduled appointments will be removed from the schedule and discharged from therapy.** We will attempt to notify you by phone. This policy will be strictly enforced.
- **Please be early or on time.** You are scheduled for a set amount of time based on your physician's request. Typically we do not have the ability to go beyond your scheduled time so you will likely lose valuable therapy time when you are late.
- **Inactive clients will be discharged.** Based on your schedule, consecutive absences may result in your discharge from the program. A notice will be sent to you and your physician. You must return to your physician and obtain a new prescription prior to receiving a new evaluation.
- **If you have a change in medical status or hospital admission your status will be changed to inactive or you will be discharged.** For your own protection, you must obtain a release from your physician and be re-evaluated before returning to the active schedule.
- **Any discharge based on poor attendance will be reviewed before any future evaluations.**

### 3. Appreciation

We appreciate your business and will make every effort to accommodate a time that is mutually convenient. Exceptions to the policy will be considered on a case-by-case basis. If you feel that you have a situation requiring special consideration please contact the Adult Scheduler.

### 4. Signature & Agreement

I have read and understand the Attendance Policy and agree to comply.

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client/Caregiver

\_\_\_\_\_  
Date

**Social Service Survey**

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Preferred Language: English Spanish Other \_\_\_\_\_

Occupation:  Student Part Time  Full Time Retired Off work temporarily Other

	1. Do you need the Social Worker to help with these items?		2. If yes - is the need immediate?		3. If yes - will the need affect your treatment goals	
Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Dental	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Self Care	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Emotional Help	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Behavioral Help	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Financial Assistance	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Employment Assistance	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Abuse/Neglect/Exploitation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Support System	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Housing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Client: \_\_\_\_\_ Client #: \_\_\_\_\_

### Medication List

Name of Prescription Medication	Prescribing Physician	Telephone Number of Prescribing Physician

### Over the Counter Medications

_____	_____
_____	_____
_____	_____
_____	_____

Please complete this information and bring it with you at your next visit.  
Thank you.