

INFORMATION FORM

Date _____

Patient Name _____ Date of Birth _____

Address _____

City/State _____ Zip code _____

Phone (Home) _____ Phone (Work) _____

Policy holder name: _____

SS#(of policy holder) _____ Date of Birth _____

Employer _____

School (if patient is a student) _____

Insurance Co: _____

Referral Source: _____

Marital Status:

Never Married Married Divorced Separated Widowed Other

Family Members:

Name	Birth Date	Relationship
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What concern brings you to counseling?

What changes do you want to see as a result of counseling?

INSURANCE INFORMATION

* Insurance Co./HMO/Managed Care Co. _____
Phone _____
* Member ID# _____ Member DOB _____
* Claims Address _____ Phone _____

EMERGENCY INFORMATION

Emergency Contact: _____ Phone _____
Relationship to Patient _____

MEDICAL HISTORY

Currently under doctor's care? Yes No Date of last Physical Exam: _____

Doctor(s) involved in your care: _____

Name of your Primary Care Physician: _____
Address: _____
Phone Number: _____

Health problems (including allergies): _____

Medication currently using: (if none, state none)

Medication	Dosage	Doctor Prescribing	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency:

Date	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST PSYCHIATRIC HISTORY
(Mental Health and Chemical Dependency)

Prior Outpatient Therapy - include previous practitioners, dates of treatment, previous treatment interventions, and response to treatment interventions (including responses to medications) _____

Client Information and Acknowledgment of Informed Consent to Treatment Form

Your Therapist

Jim Heisel is a licensed independent social worker and a licensed independent chemical dependency counselor engaged in private practice providing mental health and substance abuse care services. I provide these services as a shareholder and employee of Heisel and Associates Inc.

Mental Health and Substance Abuse Services

The purpose of receiving mental health or substance abuse care services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Jim Heisel, using his knowledge of human development and behavior will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by Jim Heisel.

The services I offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse care services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Appointments

Appointments are made by calling (513) 794-1667 ext. 1. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third party payors will not cover or reimburse for missed appointments. Appointments are 50 minutes in length, but may vary for clinical reasons. The number of appointments depends on many factors and will be discussed by Jim Heisel with you.

Relationship

Your relationship with Jim Heisel is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that Jim Heisel not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Jim Heisel cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by Jim Heisel and to have input into setting the goals of your therapy. As therapy progresses, these goals may change. You and Jim Heisel will jointly determine how to effect the changes you are seeking to make for yourself.

Confidentiality

The law protects the privacy of all communications between a client and a therapist. In most situations, Heisel and Associates, Inc. can only release information about your treatment to others if you sign a written authorization form.

There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example,

- If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order. If you are involved in or

contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

- If a government agency is requesting the information, we may be required to provide it.
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend the therapist.
- If you file a worker's compensation claim, we must, upon appropriate request, provide a copy of your records or a report of your treatment.

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

- If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
- If the therapist believes you present a clear and substantial danger of harm to yourself or and/or others, he or she will take protective actions. There may include contacting family members, seeking hospitalization of you, notifying any potential victim(s), and notifying the police.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with Jim Heisel any questions or concerns you may have.

Professional Records

The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of \$.25 per page. If we refuse your request for access to your records, you have the right of review, which we will discuss with you upon request.

In addition, as your therapist, I may also keep a set of psychotherapy notes which are for my own use and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

Authorization to Warn or Inform Third Parties

In the event that Jim Heisel reasonably believes that I am a danger, physically or emotionally, to myself or another person, by signing this Client Information and Acknowledgment of Informed Consent to Treatment, I

specifically consent for Jim Heisel to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons listed below:

Name

Telephone Number

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization to Warn or Inform Third Parties shall expire upon the termination of my therapy with Jim Heisel.

I acknowledge that I have the right to revoke the above authorization to warn or inform third parties, in writing, at any time to the extent that Jim Heisel has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could still be permitted by law as indicated in the copy of the Notice of Privacy Practices of Jim Heisel that I have received and reviewed.

After-Hours Emergencies

Jim Heisel is on call , or has a colleague on call, when the office is closed or he is out of town. You can reach Jim by contacting him at (513) 543-7838, or you can reach a colleague by calling the office and checking Jim's answering machine message at (513) 794-1667 ext. 1. You can also go directly to a hospital emergency room or call 911. Emergencies are urgent issues requiring your immediate action.

Jim Heisel's Incapacity or Death

I acknowledge that, in the event that Jim Heisel becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I give my consent to allowing another licensed mental health or substance abuse professional selected by Jim Heisel to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health or substance abuse professional.

Consent to Treatment

I, voluntarily, agree to receive mental health or substance abuse assessment, care, treatment, or services and authorize Jim Heisel to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through Jim Heisel at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name

Client Signature

Date

Parent or Guardian Signature (for minor child)

Date

I may be contacted at the following:

Address: _____

City/State/Zip: _____

Telephone: _____

Email: _____

Witnessed by:

Date

SAMPLE

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present and future physical and mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the National Association of Social Workers *Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose that minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating and determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI.

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Jim Heisel at 10921 Reed Hartman Hwy., Suite 206, Cincinnati, Ohio 45242.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice

COMPLAINTS.

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Jim Heisel at 10921 Reed Hartman Hwy., Suite 206, Cincinnati, Ohio 45242, or with the Secretary of Health and Human Services at 200 Independence Ave. SW, Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Heisel and Associates Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jim Heisel at 10921 Reed Hartman Hwy., Suite 206, Cincinnati, Ohio 45242 or 513-794-1667.

Signature of Patient/Client *Date*

*Signature or Parent, Guardian or Personal Representative ** *Date*

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Patient/Client Refuses to Acknowledge Receipt:

Signature of Counselor *Date*

Statement of Fees

Receipt, Acknowledgement of Notice & Agreement to Pay for Services

Patient/Client Name: _____

DOB: _____

SSN: _____

Jim Heisel/Heisel and Associates charges a fee for providing services. Our standard fee is \$80 for a 50 minute session, however managed care and insurance company contracts may have pre-set fees that we are required to accept. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health or substance abuse treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health or substance abuse services your policy covers.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

Client Acknowledgment

I hereby acknowledge that I am personally responsible for the fees charged for receiving services. I understand that insurance claims are submitted only as a service. I also understand that I must give 24 hour notice of cancellation to avoid being charged a cancellation fee for failing to attend an appointment I have made.

Signature of Client

Date

Signature of Parent, Guardian or Responsible Party

Date

Credit Card Guarantee:

Jim Heisel/Heisel and Associates asks that you provide a credit card guarantee in the event that your insurance company fails to pay for services or you fail to make your co-payments. We want you to understand that we will only bill your credit card after 60 days have passed since the provision of services and we have twice sent you invoices, giving you an opportunity to pay for services. We only charge for the contracted rate we have with the insurance, or managed care, company, minus any payments they or you have made on your claim.

Permission to Bill Credit Card

I am voluntarily offering this credit card guarantee in the event that my managed care or insurance company denies my claim, I neglect to pay my co-payment(s), or for any other reason payment for services is not made. I am authorizing Jim Heisel/ Heisel and Associates Inc. to bill my credit card for any outstanding balance due 60 days after provision of services.

Master Card ___ **Visa** ___ **Expiration Date:** _____

Card Number: _____

Signature: _____

SAMPLE

INITIAL EVALUATION/ASSESSMENT

Client Name: _____ Date: _____

Presenting Problem/Precipitating Event (onset, duration, intensity, and why now) _____

Target Symptoms:	<u>Symptom</u>	<u>Frequency/Duration</u>	<u>Degree of Impairment</u>
Symptom #1	_____	_____	_____
Symptom #2	_____	_____	_____
Symptom #3	_____	_____	_____

Mental Status (circle appropriate items):

Appearance:	Appropriate	Inappropriate	Disheveled	Unclean	Bizarre
Affect:	Appropriate	Inappropriate (describe) _____ (sad, angry, anxious, superficial, restricted, labile, flat)			
Orientation:	Oriented	Disoriented (to person, place, time, date, day, situation)			
Mood:	Normal	Other _____ (sad, depressed, irritable, angry)			
Thought Content:	Appropriate	Inappropriate			
Thought Process:	Logical	Tangential	Illogical		
Speech:	Normal	Slurred	Slow	Pressured	Loud
Motor:	Normal	Excessive	Slow	Other _____	
Intellect:	Average	Above	Below		
Insight:	Present	Partially Present	Absent		
Judgment:	Normal	Impaired			
Impulse Control:	Normal	Impaired			
Memory:	Normal	Impaired: Immediate, Recent, Remote			
Concentration:	Normal	Impaired			
Attention:	Normal	Impaired			
Behavior:	Appropriate	Inappropriate (anxious, agitated, guarded, hostile, uncooperative, drowsy, hyperactive, psychomotor retarded)			
Thought Disorder:	No Problem	Delusions, grandiosity, paranoia, ideas of reference, tangential, Loose associations, perseveration, confusion, thought blocking, Obsessions, flight of ideas			

PSYCHOSOCIAL INFORMATION:

Support Systems _____

School/Work Life _____

Marital History _____

Legal History _____

Military History _____

Spiritual Beliefs _____

Risk Assessment

	None Noted	Thoughts Only	Plan (describe)	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation							
Homicidal Ideation							

Family Mental Health or Chemical Dependency History: _____

SUBSTANCE ABUSE HISTORY (complete for all patients of age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/ Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Risk Factors noted to include:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Non-compliance with treatment
<input type="checkbox"/> AMA/elopement potential
<input type="checkbox"/> Prior behavioral health inpatient admissions
<input type="checkbox"/> History of multiple behavioral diagnoses
<input type="checkbox"/> Suicidal/homicidal ideation | <input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Child Abuse
<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Other (describe) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

TREATMENT PLAN

**** All treatment goals must be objective and measurable, with estimated time frames for completion. The treatment plan should be developed with the patient, and the patient's level of understanding/acceptance of the goals developed should be documented.**

Treatment Goals [after each item selected, indicate outcome measures (i.e. "as evidenced by")]

- ___ **Reduce Risk Factors of:** _____
- ___ **Reduce Major Symptoms of:** _____
- ___ **Improve Functional Impairment of:** _____
- ___ **Develop Coping Strategies to Deal with Stress of:** _____
- ___ **Stabilize (short term) Crisis of:** _____
- ___ **Maintain (long term) Stabilization of Symptoms of:** _____
- ___ **Medication referral to:** _____

Planned Interventions-Patient Participation (must be consistent with treatment goals):

- ___ **Assertiveness Training**
- ___ **Anger Management**
- ___ **Affect Identification and Expression**
- ___ **Cognitive Restructuring**
- ___ **Communication Training**
- ___ **Grief Work**
- ___ **Imagery/Relaxation Training**
- ___ **Parent Training**
- ___ **Problem Solving Skills Training**
- ___ **Solution Focused Techniques**
- ___ **Stress Management**
- ___ **Supportive Therapy**
- ___ **Self/Other Boundaries Training**
- ___ **Decision Option Exploration**
- ___ **Pattern Identification and Interruption**
- ___ **Engage Significant Others in Treatment:** _____
- ___ **Facilitate Decision Making Regarding:** _____
- ___ **Explore/Monitor:** _____
- ___ **Teach Skills of:** _____
- ___ **Educate Regarding:** _____
- ___ **Assign Readings:** _____
- ___ **Assign Tasks of:** _____
- ___ **Referrals Planned:** _____
- ___ **Use of resources/strengths:** _____
- ___ **Preventive Strategies:** _____
- ___ **Obstacles to change:** _____

The provider and I have developed this plan together, and I am in agreement to working on these issues and goals. I give my permission to disclose the above assessment and treatment plan to my primary care physician for the purpose of medical supervision and ongoing care.

Client Signature _____ **Date** _____

Therapist Signature _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (insert name of client), whose Date of Birth is _____ authorize Heisel and Associates to disclose to and/or obtain from: _____

The following information is to be released:

- | | |
|-----------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Other _____ | |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I understand I have a right to revoke this authorization, in writing, at any time by sending written notification to Jim Heisel, 10921 Reed Hartman Hwy., Suite 206, Cincinnati, Ohio 45242. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless sooner revoked this consent expires on the following date _____

I further understand that Jim Heisel/Heisel and Associates will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Jim Heisel/Heisel and Associates reserves the right to disclose information as permitted in this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2.

Signature of Client

Date

Signature of Parent, Guardian or Personal Representative

Date

Check here if client refuses to sign authorization.

Signature of Witness

Date