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	Date of Birth	Relationship

What concern brings you to counseling?

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

Client Information and Acknowledgment of Informed Consent to Treatment

Therapist: James Heisel, LISW-S, LICDC-CS, is a licensed independent social worker and a licensed independent chemical dependency counselor, engaged in the private practice of providing mental health and substance abuse care services through Heisel and Associates, Inc.

Nature and Purpose of 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. Using my knowledge of human development and behavior, I will make observations about situations as well as suggestions for new ways to approach them. It is important for you to examine your own feelings, thoughts, and behavior, and to try new approaches in order for change to occur.

The services I offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as 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. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Extent and Timeframe of Services; Appointments: Appointments are made by calling 513-271-3923. Appointments are typically 50 minutes in length, but may vary. We will discuss the number of appointments you may need.

Fees: The standard fee is $80.00 for a 50 minute session, however, certain managed care and insurance company contracts may have pre-set fees. If your health insurance policy does not provide coverage for my services or denies coverage, then you are responsible for payment of fees. Please see the document entitled, “Notice of and Agreement to Pay Fees” for additional information.

Missed Appointments: There is also a cancellation fee for failing to attend a scheduled appointment without giving 24 hours notice of cancellation. Insurance will not cover or reimburse for missed appointments and you are responsible for payment of the cancellation fee.

Relationship: As my client, we will have a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine our professional and therapeutic relationship. While I care about helping you, I cannot have a social or personal relationship with you.

Goals: There may be alternative ways to treat the problems you are experiencing. It is important for us to discuss any questions you may have regarding your treatment and for you to have input into setting the goals for your therapy. As your therapy progresses, these goals may change. I will work with you to address the changes in your goals.

Privacy: Please see the document entitled, “Notice of Privacy Practices”

Professional Records: I am legally required to keep documentation about the services I provide to you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways problem affects your life, your diagnosis, your treatment goals, your progress toward those goals, your medical, social, and treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from others, reports of any

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

To What Health Information Does This Notice Apply? Protected Health Information is information that you provide us or that we create or receive about you and your health care and treatment, including but not limited to your name, age, race, sex, and other personal identifying information, information related to your physical or mental health in the past, present, or future, information related to your care, treatment, services, and information related to payment for your care, treatment, and services (herein, “Protected Health Information” or “PHI”).

Who Must Follow This Notice? Heisel and Associates, Inc. is required to comply with the privacy practices described in this Notice. We reserve the right to change this Notice and to make any new practices effective for PHI we already have and for PHI that we receive in the future. Any changes made to this Notice will be posted at Heisel and Associates, Inc.’s website (www.heiselandassoc.com) and made available to you at your next appointment.

Ways We Can Share Your PHI Without Your Written Permission:

In certain situations, described below, we require your written permission to share your PHI, however, we do not need any type of permission from you to share your PHI in the following circumstances:

A. We must share your PHI to provide that information to you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this Notice.

B. Sharing Your PHI for Treatment, Payment and Health Care Operations. We may share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and/or perform our "Health Care Operations.” This is what these terms mean:

i. Treatment: We share your PHI to provide care and other services to you, for example, to provide a mental health evaluation. In addition, we may contact you to provide appointment reminders or information about treatment options.
ii. Payment: We may disclose your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from your health insurance company (“Payor”) and to confirm that your Payor will pay for services that we provide to you. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.
iii. Health Care Operations: We may share your PHI for our health care operations, which include management, care coordination, planning, and activities that are intended to improve the quality and lower the cost of our services.

C. We may share your PHI to Business Associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our Business Associates are required both by law and under contract with us to protect the privacy of your PHI and are not allowed to share any information other than as required by law or specified in our contract.

D. Data Breach Notification Purposes. We may share your PHI to provide you with notice about the unauthorized acquisition, access, or disclosure of your PHI.

E. Public Health Activities. We are required or are permitted by law to report your PHI to certain

INITIAL EVALUATION/ASSESSMENT

Client Name _____ **Date** _____

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

_____

_____

_____

_____

_____

Target Symptoms: **Symptom** **Frequency/Duration** **Degree of Impairment**

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 _____

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Name of Client _____
Last First Middle
Other Possible Names _____

Date of Birth _____ **Phone** _____

Address _____

City/State _____ **Zip Code** _____

I hereby authorize Heisel and Associates, Inc. to use and disclose the information indicated below to:

Name _____

Address _____

Phone _____ **Fax** _____

Information may be: ☐ Mailed ☐ Reviewed Only ☐ Picked up by: _____

Information may be: ☐ Mailed ☐ Reviewed Only ☐ Picked up by: _____

Information to be used and disclosed (check all that apply):
From and to dates: _____
☐ Personal Identifying Information ☐ Assessment ☐ Diagnosis ☐ Psychosocial Evaluation ☐ Treatment Plan ☐ Current Treatment Update ☐ Presence/Participation in Treatment ☐ Discharge/Transfer Summary ☐ Continuing Care Plan ☐ Progress in Treatment ☐ Demographic Information ☐ Billing and Payment Information ☐ Other _____

I understand that information to be used and disclosed may include protected health information, HIV-related information, and/or information relating to diagnosis or treatment of mental illness and/or substance abuse and that by signing this Authorization, I am authorizing the use and disclosure of information relating to (check all that apply):
☐ **Substance Abuse (including alcohol/drug abuse)**
☐ **Mental Health Treatment**
☐ **HIV related information (including AIDS related testing)**

Purpose for the use and disclosure (check all that apply):
☐ Changing provider ☐ Second opinion ☐ Continuing care ☐ Legal ☐ Personal
☐ Insurance ☐ Workers' Compensation ☐ School ☐ Payment ☐ Other_____

I understand and agree as follows:

a. This Authorization will expire 6 months from my last date of service provided by James Heisel and Heisel and Associates, Inc. I may shorten, extend, or revoke this Authorization at any time by notifying Heisel and Associates, Inc. in writing at 10921 Reed Hartman Highway, Suite 212, Cincinnati, Ohio 45242, which will be effective on the date the notice is received except to the extent action has been taken in reliance upon this Authorization;

b. If I am receiving treatment related to mental health or substance abuse, I authorize James Heisel and