New Client Information

Legal Name _____ Date _____
Preferred Name _____

Mailing Address _____

_____

Please Check: _____

☐**Yes** ☐**No** Do we have your authorized permission to send you mail for administrative purposes only that may include Protected Health Information (PHI) such as your name or your receipts?

Phone (Cell) _____

☐**Yes** ☐**No** Can we call you and receive calls from you at this number?

☐**Yes** ☐**No** Do we have your authorized permission to leave you a message at this number for the purpose of scheduling only, that may include PHI (ie your name, our name and the reason for the call)?

Phone (Home) _____

☐**Yes** ☐**No** Can we call you and receive calls from you at this number?

☐**Yes** ☐**No** Do we have your authorized permission to leave you a message at this number for the purpose of scheduling only, that may include PHI (ie your name, our name and the reason for the call)?

Email: _____

☐**Yes** ☐**No** Do we have your authorized permission to send you email or respond to email from you for the purpose of scheduling only, that may include PHI (such as your name, our name, appointment dates)?

☐**Yes** ☐**No** Do you want to receive our Quarterly Newsletter, *Healing Times: Strategies for Healthy Living?*
******Note: We will not sell or distribute any email addresses under any circumstances.

Date of Birth _____/_____/_____ If under 18, parent/guardian's Name _____

Age _____ Phone Number _____

Emergency Contact Information

Name _____ Relationship _____ Phone _____
**We will only contact this person if we suspect a life threatening emergency.

How did you hear about us? _____

As a professional courtesy, may we send a note to thank them for the referral? ☐ Yes ☐ No

Thank you for choosing a therapist located at Gaithersburg Counseling Center for your services.

Contract For Services

1. Following is the contract for services between your provider (Clinician) and _____ (Client Name). This contract is dated _____/_____/_____, and will remain in effect until both parties agree to written changes.

2. Credentials:

- Clinician is a Licensed Certified Social Worker - Clinical, Licensed Clinical Professional Counselor, Licensed Graduate Social Worker or Licensed Graduate Professional Counselor in the State of Maryland. Clinician also obtained a professional Masters degree, and is committed to providing professional mental health care to the Client.

3. Client Rights and Important Information:

- Client is entitled to receive information about methods of therapy, therapy techniques used and the duration of therapy (if it can be determined by Clinician). Consult your Clinician regarding your care, about any questions or discussion regarding Clinicians specific therapy methods and techniques.
- Generally, the information provided by and to Client during therapy sessions is legally confidential, meaning that the Clinician cannot disclose confidential information without the Client's consent. Noted exceptions to this general rule are listed below:
  *For more detailed information, see the attached Notice of Privacy Practices (NPP).
  - If you sign a written Release of Information for a specific person for a specific reason.
  - When the clinician suspects or determines, the client is a danger to themselves or others.
  - Information concerning any type of abuse of children or vulnerable adults.
  - Case consultation with other mental health professionals.
    *No identifying information will be shared.
  - Administrative communication with administrative office staff for administrative purposes only such as scheduling, billing or other administrative documents.
  - When a court order or subpoena requires release of Client records.
  - To defend myself in a lawsuit by a client.
  - *Note, if you are using Employee Assistance Program (EAP) services, the EAP, not your employer, may be notified of your session dates, primary assessed issues, goals and outcome, as well as the therapist's clinical recommendations.
- Client has the right to express any grievances regarding dissatisfaction with therapy services. Client may send a written complaint to the Secretary of the U.S. Department of Health and Human Service. We ask Client to also discuss any dissatisfaction with Clinician directly to improve the quality of our care.

4. Fee Information:

Minutes	Amy Hooper, LCSW-C, CEAP	Lev Grotel, LCSW-C	Jill Abramson, LCSW-C	Tamar Barnett, LCPC	Shana Spier, LGSW	Colleen Fitzgerald, LGPC, NCC	Cathy Caldwell, LGPC	Jing Yang, LGPC
○ 50-60 Intake	$160	$140	$140	$140	$130	$125	$120	$130
○ 45-50 Individual	$150	$120	$130	$130	$130	$120	$120	$130
○ 50-60 Couples	$160	$140	$140	$140	$130	$125	$120	$130
○ 50-60 Family	$160	$140	$140	$140	$130	$125	$120	$130

- *Note, if you are using EAP services, the EAP is responsible for payment for all authorized visits.
- **Full fee will be charged for any missed or canceled appointments with less than 24 business hours notice.** Monday appointments must be canceled by Friday. One "exception pass" will be given each year for an emergency, illness, or circumstance beyond your control.

4. Fee Information Continued:
    - There will be a $25.00 fee for any returned checks.
    - Outstanding payments that are not received within 60 days will be charged a $25 late fee.
    - No charges will be assessed for brief or occasional telephone calls. However, if there are frequent telephone calls lasting more than 10 minutes, Client will be billed proportionately.
    - Fees may change in the future and if the do, Client will be notified in writing at least 30 days prior to any fee change.
    - Clinician does not complete or submit claims to your insurance company. Insurance filing is the responsibility of the client. If your insurance company covers and authorizes reimbursement, they will pay you directly. The information the insurance carriers usually require will be included on the insurance receipt. Receipts are printed monthly unless you request otherwise.
    - Clinician does not accept 3rd party payments from insurance companies, health savings accounts, workman's compensation, attorneys or disability services. All payments are to be made directly from Client.

5. Office Policies

    - Effective psychotherapy requires a good match between Client and Clinician. The first sessions will determine if Clinician is the right provider for Client. If not, Clinician will help find a provider to better meet Clients needs.
    - Clinician will do their best to help Client achieve their goals, but cannot guarantee any particular result. The more active a role Client takes in treatment, the more Client will benefit from the services rendered.
    - Lateness by the Client doesn't alter the session fee or ending time. Clinician lateness will always be made up.
    - In the event of inclement weather, call your therapist to find out if your session is cancelled. If Montgomery County Government is closed, and Client is unable to attend their scheduled session, Client will not be charged.
    - Due to safety reasons, we cannot have any children less than 13 years old left unattended on our waiting room.
    - Clinician does not complete court reports, recommendations for custody, disability applications, or psychological testing. If you require these documents, Clinician can refer you to a specialist.
    - Client waives their right to request records in the event of a legal matter as your clinician is ethically compromised if they get involved in the legal matters of their clients.
    - While sessions may be intimate emotionally and psychologically, it is important to know the relationship between Client and Clinician is professional and not a friendship. Contact is limited to paid therapeutic sessions as well as phone or email contact for the purpose of administrative needs or scheduling requests.
    - The Protected Health Information about Client in the clinical record is available for you to review. Unless disclosing the record to Client will likely endangers Client or someone else's safety, Client can review or receive a copy of the records if a request is made in writing 30 days in advance. Due to the sensitive nature of these records, it is recommended to review them with your clinician present. There is a standard copying fee of $.25 per page. Alternatively, Client has a right to a summary of services sent to Client or to another provider.
    - If documentation is required, there will be a set fee for any completion of forms, preparation of a summary or assessments. Please discuss these fees with your provider before any additional paperwork is completed.
    - Clinician is directly responsible for the care, maintenance and property of the client records. Records requests will be made directly to the Clinician even if they are no longer contracting with Another Look at Healing, LLC.

- It is impossible to guarantee the confidentiality of email or text messaging content. You acknowledge the risks and release therapists from liability for the risk to your confidentiality when you chose to email or text your therapist. For more private communication, call your therapist directly or schedule a session to talk in the office.
- All Clients and Clinician emails will be limited to administrative issues (ie scheduling or billing). Client understands that fax and email communication may be intercepted by others and Clinician is not responsible if such interceptions occur. Clinician will limit their communication to the methods documented by the Client in this agreement, given the limitations listed above.
- It is our policy to not accept friend requests from clients on Facebook, Linked In or other social media websites. We cannot protect confidentiality if you connect with us via social media.
- By signing this form, you consent to release your contact information and, if necessary, clinical records to a designee, in the event your clinician has an emergency and they are unable to contact you themselves.
- Client has the right to terminate services at any time. It is most helpful and recommended that Client discuss termination with Clinician before discontinuing. All Clients are mailed a closure letter at the end of treatment.

6. Emergencies and After Hours:

- Office phone is for non-emergency voicemail only. Your clinician does not offer after hour emergency services.
- **If you have an Mental Health or Medical emergency, please call 911, go to your nearest emergency room or call the Montgomery County Crisis Center at (240) 777-4000 or walk in at 1301 Piccard Drive, Rockville, MD**

By my signature I am affirming that I understand and accept the policies described in this document and that I have received copies of the Notice of Privacy Practices. By agreeing to psychotherapeutic treatment, I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. If Client is under eighteen years of age, responsible Guardian agrees to all terms and conditions of contract and is legally bound by the same terms as Client.

Client Name	Client Signature	Date
Legal Guardian Name (if Client is under 18)	Legal Guardian Signature	Date
Legal Guardian Name (if Client is under 18)	Legal Guardian Signature	Date
Clinician Name	Clinician Signature	Date

Client Intake

What do you want to focus on in therapy? _____

_____

_____

Are you feeling: ☐ Depressed ☐ Anxious ☐ Angry ☐ Suicidal ☐ Homicidal ☐ Happy
☐ Frustrated ☐ Worried ☐ Hurt ☐ Afraid ☐ Confused ☐ Elated

Counseling History:

Have you received any previous counseling or other therapeutic assistance? ☐ Yes ☐ No
Please explain (including when, for how long, was it helpful?)

_____

_____

Medical History:

Are you suffering from any Medical conditions at this time? If yes, please explain (use back if needed):

_____

Medication, non-prescription drugs, & herbal supplements you are now using / and the amount?

_____

LifeStyle Information:

Describe your weekly exercise frequency: ☐ 0-1 session ☐ 2-4 sessions ☐ 5-7sessions ☐ 8+ sessions

Describe your nightly sleep: ☐ 0-5 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 9-10 hours ☐ 11-12 hours ☐ 12+ hours

Describe your daily technology use (computer, phone, tablet etc.): ☐ 0-2 hrs ☐ 3-4 hrs ☐ 5-7 hrs ☐ 8+ hrs

Describe your daily caffeine use: ☐ 0-1 cup ☐ 2-3 cups ☐ 3-5 cups ☐ 6+cups

Describe your daily tobacco use: ☐ 0-1 cigarette ☐ 2-4 cigarettes ☐ 5-10 cigarettes ☐ 11+ cigarettes

Describe your daily alcohol use: ☐ 0-1 drink ☐ 2-3 drinks ☐ 3-5 drinks ☐ 6-8 drinks ☐ 9+ drinks
Describe your daily drug use: Type of Drug _____ Amount Used _____

Family History:

Are you? ☐Single ☐Committed Relationship ☐Married ☐Divorced/Separated ☐Other_____
Do you have any children? (names/ages) _____
Who is living in your home now: _____

Risk Assessment:

Are you having or had in the past any thoughts of hurting yourself or others? Please explain:

_____

_____

Describe the use of alcohol and drugs by <u>*those living with you*</u>: _____

_____

_____

Have you or family members, in the <u>past</u> or at <u>present</u>, had problems/addiction with drugs, alcohol, food, sex, gambling, other? Please explain:_____

_____

_____

HIPAA: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights - You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures - We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights - When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

Your Choices - For certain health information, you can tell us your choices about what we share. **If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.**
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures - How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
Notice must also include: Effective Date of this Notice: 9-22-13