CLIENT INFORMATION SHEET Date_____

Name_____ DOB_____

Street_____ City_____ Zip_____

Marital Status: M S D W Sex: M F Occupation:_____

Spouse:_____ Child(ren):_____

Religion:_____ Referred by:_____

Insurance Carrier:_____ Subscriber (& DOB):_____

Is it permissible to:

Primary phone #: (H, C, W)_____ Call? Y N Text? Y N Leave message? Y N

Secondary phone #: (H, C, W)_____ Call? Y N Text? Y N Leave message? Y N

Email address:_____ Send correspondence? Y N

If patient is a minor:

Mother's name:_____ Address:_____ Phone:_____

Father's name:_____ Address:_____ Phone:_____

Health Data

Medical History:_____

Family History (medical & psychological):_____

Habits (alcohol, drugs, eating & sleeping):_____

Medication (include purpose):_____

Previous medication for emotional problems:_____

Reason for seeking counseling:_____

_____

Previous psychotherapy, counseling or other treatments for emotional problems:

Dates Type of Problem Name of Professional or Agency

_____

Emergency Contact_____ Phone:_____

I understand that my mental health issues may be discussed with the above person. _____

Signature

Judy Howell, M. Ed, LMHC
Paula Oliveira, LICSW
80 Route 125
Kingston, NH 03848
(603) 642-6700
www.newcreationhc.org

INFORMED CONSENT (PLEASE READ ALL INFORMATION & SIGN THE LAST PAGE:

CONFIDENTIALITY –

A. In order for therapy to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of treatment. Ethically and legally, all mental health professionals are bound to keep all of this information strictly confidential and not release it to any party without your written permission. However, there are certain exceptions to this rule of which you should be aware.

1. There are certain situations in which a therapist is legally bound to act even if doing so should breach therapeutic confidentiality. These are as follows:
   First, if it is believed that a child under the age of 18 has suffered, is suffering or is in danger of suffering serious physical or emotional abuse, or has been or is being sexually abused, a report must be made to the proper government authority. The same holds true for elderly persons who are suffering or have died due to abuse or neglect.
   Secondly, if it is believed that you are threatening immediate harm to yourself, through plan of action or inaction, he/she is required to contact a family member or other person who can help protect you, or have you evaluated for hospital admission.
   Finally, if you were to threaten physical violence against another person, there exists the obligation to take some action to protect the person by notifying him/her and the police and seek to have you hospitalized to prevent harm.
2. In legal proceedings, the courts usually respect your rights to confidentiality in the treatment relationship, and I am ethically bound to protect that right when testifying in legal or administrative procedures, even when a lawyer issues a subpoena. However, there are circumstances where some judges overrule privilege and issue a court order requiring the therapist to testify. A typical situation where confidentiality privileges are over-ruled is in a contested custody procedure in divorce.
3. It is my practice to consult with colleagues within the practice regarding clinical matters and on-call coverage. Full confidentiality, therefore, cannot be maintained, although the information shared is only that necessary for consultation.

B. MINORS – In cases of therapy with minors, parents of legal guardians have rights to information regarding treatment. However, in order for therapy to be effective, the child must have an assurance of confidentiality. Because of this, it is my policy when doing therapy with minors, to ask parents to waive their rights to the confidential information. Information will be shared only with the child's permission, except in situations where the child's welfare is being compromised by maintaining the confidentiality.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, together it is important to evaluate what resources are available to pay for your treatment. If you have health insurance, it will usually provide some coverage for mental health treatment. However, insurance plans vary widely in what they will and will not cover. It is very important that you find out exactly what mental health services your insurance policy covers. Read your insurance coverage documents carefully. If you have questions, make sure you contact your plan and inquire.

You should also be aware that all insurance agreements require you to authorize the therapist to provide clinical information such as diagnosis and some clinical treatment plans or a copy of an entire record. Once in the hands of the insurance company, I have no control what they do with the information. If you request it, the submitted report can be shared with you.

If it is an option for you to use your insurance coverage, it is important to discuss what we can expect to accomplish the benefits that are available and what will happen should your benefits expire before you feel ready to end treatment. If you chose not to involve your insurance company or it is not an option then you will need to pay for services yourself on the day they are received. A fee schedule is available upon request.

MENTAL HEALTH BILL OF RIGHTS:

"This Mental Health Bill of Rights is provided by law to persons receiving mental health services in the State of NH. Its purpose is to protect the rights and enhance the well-being of clients, by informing them of key aspects of the clinical relationship. As a client of a NH Mental Health Practitioner, you have, without asking, the right:

1) To be treated in a professional, respectful, competent and ethical manner consistent with all applicable state laws and the following professional ethical standards: for independent clinical social workers, the NASW.
2) To receive full information about your treatment provider's knowledge, skills, experience and credentials.
3) To have the information you disclose to your mental health provider kept confidential within the limits of state and federal law. Communications between mental health providers and clients are typically confidential, unless the law requires their disclosure. Mental health providers will inform you of the legal exceptions to confidentiality and should such an exception arise, will share only such information as required by law. Examples of such exceptions include but are not limited to: abuse of a child; abuse of an incapacitated adult; HIPPA regulation compliance; certain rights you may have waived when contracting for third party financial coverage; orders of the court; and significant threats to self, others or property.
4) To a safe setting and to know that the services provided are effective and of a quality consistent with the standard of care within each profession and to know that sexual relations between mental health provider and a client or former client are a violation of the law (RSA 330-A:36).
5) To obtain information, as allowed by law, pertaining to the mental health provider's assessment, assessment, assessment procedures and mental health diagnoses.
6) To participate meaningfully in the planning, implementation and termination or referral of your treatment.
7) To documented informed consent: to be informed of the risks and benefits of the proposed treatment, the risks and benefits of alternative treatments and the risks and benefits of no treatment. When obtaining informed consent for treatment for which safety and effectiveness have not been established, therapists will inform their clients of this and of the voluntary nature of their participation. In addition, clients have the right to be informed of their rights and responsibilities, and of the mental health provider's practice policies regarding confidentiality, office hours, fees, missed appointments, billing policies, electronic communications, managed care issues, record management, and other relevant matters except otherwise provided by law.
8) To obtain information regarding the provision(s) for emergency coverage.

9) To receive a copy of your mental health record within 30 days upon written request (except as otherwise provide by law), by paying a nominal fee designed to defray the administrative costs of reproducing the record.
10) To know that your mental health provider is licensed by the State of NH to provide mental health services.
    a. You have the right to obtain information about mental health practice in NH. You may contact the Board of Mental Health Practice for list names, addresses, phone numbers and websites of state and national professional associations listed in Mhp 502.02 (a)(1)(a-e).
    b. You have the right to discuss questions or concerns about the mental health services you receive with your provider.
    c. You have the right to file a complaint with the Board of Mental Health Practice."

_____
Please print the name of patient

_____ _____
Signature of patient or legal guardian, if a minor Date

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FINANCIAL POLICY

I have made prior arrangements with many health plans to accept an assignment of benefits. I will bill all insurance companies. If you receive a check from your insurance company for services you received from me it is your responsibility to pay me. You are required to pay your co-payment at the time of your visit. If your copay is not paid at the time of your visit, there will be a $5.00 fee assessed. If I do not receive payment from your insurance company within a reasonable amount of time, we will send a bill to you. If you have insurance with a plan I do not have an agreement with, I expect payment at the time of the service. In the event your health plan determines a service to be "not covered", you will be responsible for the total charge. Payment is due upon receipt of any statement from me. Any balance due is your responsibility and is due upon receipt of a statement from me. If I must mail more than one statement, there will be a service charge for each statement sent.

RETURNED CHECKS: There will be a $25.00 charge for any returned checks. You may be put on a "cash only" basis thereafter.

MISSED APPOINTMENTS: **In order to provide the best possible service and availability to my clients, it is my policy to charge an office visit fee according to the amount of time scheduled for an appointment not cancelled at least 24 hrs. prior to the visit.**

UNINSURED: Unless other arrangements have been made in advance full payment is due at the time of service. I accept VISA, Mastercard and Discover.

If you have questions about the policy, please discuss them with me. I am dedicated to providing the best possible care. I regard your understanding of your financial responsibilities as an essential element of your care and treatment.

I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____
Please print the name of the patient

_____ _____
Signature of patient or legal guardian, if a minor Date

Revised 6/17

Judy Howell, M. Ed, LMHC or Paula Oliveira, LICSW
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603-642-6700

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, treatment room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of me.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. I agree to provide patients with access to their records in accordance with state and federal laws.

8. I may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____
Signature Date