COUNSELINGBYBONNIE BONNIE K. SHINHEARL LICENSED PROFESSIONAL CLINICAL COUNSELOR

NEW OR RETURNING PATIENT

NAME_____

(last) (first) (middle initial)

NAME OF PARENT/GUARDIAN(if under 18 years):

_____

(last) (first) (middle initial)

ADDRESS_____

_____

(city) (state) (zip)

Birth Date:_____/_____/_____Age:_____Gender:_____F____M

Marital Status:_____

Education Level_____

Who makes up your household?

Name	Age	Relationship	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME PHONE (_____)_____Other (_____)_____

PERMISSION TO LEAVE A MESSAGE? YES NO

E-MAIL:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

ID#_____GROUP#_____

EMPLOYER_____

PARENT/GUARDIAN _____PHONE_____

PARENT ADDRESS_____

GUARANTOR/RESPONSIBLE PARTY

NAME (PLEASE PRINT)_____

SIGNATURE_____DATE_____

SELF-PAY

GUARANTOR/RESPONSIBLE PARTY IS RESPONSIBLE FOR SELF-PAY FEE OF $100.00 AT THE TIME OF SERVICE.

SIGNATURE_____

I N T A K E F O R M

Please fill out the information below. All information provided is protected confidential information.

Have you previously received any mental health services (psychotherapy, psychiatric services, psychiatric hospitalizations?

_____NO

_____YES, previous provider_____

Are you taking any medications?

_____NO

_____YES

Please list_____

_____

Have you ever been prescribed psychiatric medication?

_____NO

_____YES

Please list_____

_____

Are you being treated by a physician for any physical health issues?

_____NO

_____YES

Please list_____

_____

GENERAL HEALTH/MENTAL HEALTH INFORMATION

Please rate the following:

General physical health	Poor	Unsatisfactory	Satisfactory	Good	Very Good	Excellent
Sleeping habits	Poor	Unsatisfactory	Satisfactory	Good	Very Good	Excellent
Diet	Poor	Unsatisfactory	Satisfactory	Good	Very Good	Excellent

Comments_____

_____

_____

Do you exercise?

_____NO

_____YES

How many times a week and what type of exercise do you do_____
_____
_____

Briefly describe what brings you to counseling today

_____
_____
_____
_____

Are you experiencing any of the following:

_____Sadness

_____Grief

_____Depression

_____Anxiety

_____Panic attacks

_____Racing thoughts

_____Obsessive/Compulsive

_____Chronic pain

_____Family stress

_____Relationship issues

_____Work/job stress

Do you drink alcohol?

_____NO _____YES Frequency_____

Do you engage in recreational drug use?

_____NO _____YES Frequency_____

Are you currently in a romantic relationship?
_____NO _____YES
How would you characterize your relationship on a scale of 1-10 (1 being poor and 10 being excellent)
1 2 3 4 5 6 7 8 9 10

Have you experienced any recent life changes or stressful events?

_____
_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____
_____

What do you consider to be some of your weaknesses?

_____
_____
_____
_____

What would you like to accomplish during your time in therapy? What would you like the outcome to be?

_____
_____
_____
_____

Is there anything else you would like me to know about you?

_____
_____
_____

Bonnie K. Shinhearl,LLC Licensed Professional Clinical Counselor counselingbybonnie@yahoo.com

FINANCIAL POLICY/INSURANCE GUIDELINES

Initial each line

_____**CO-PAYMENTS**: All contracted insurance co-payments are required at the time of your session, in compliance with your health insurance policy. This includes deductibles. Cash, check or credit card.

_____**ACCOUNT BALANCES:** Balances are due upon receipt of your statement. These include fees not covered by your insurance company, i.e. deductible and other services such as phone calls, letters and late cancellation fees. Balances over $200 will be required to be paid-in-full before next appointment is scheduled.

_____**E-THERAPY:** These sessions are not covered by insurance. Fees are $125.00 per one-hour session.

_____**LATE CANCELLATION/NO SHOW**: A 24-hour notice is required. If you are unable to attend your scheduled appointment. This fee is not covered by insurance. Fee for late cancel is $25.00

_____**FORMS**: Forms that need to be completed outside of the session, i.e. FMLA or other, a base fee of $25.00 is required. If additional time will be required, you will be informed of the increased fee due to professional time that is needed to complete your forms. These fees are not covered by insurance.

_____**LETTERS**: Fees for letter will vary depending on the length or complex nature of the narrative. Basic letter minimum fee is $15.00. Case narrative fees range from $50.00-$100.

_____**INSUFFICIENT FUNDS:** A $25 fee for any checks returned due to Insufficient funds. This fee is not covered by insurance.

_____**SELF PAY:** Payment in full of $125.00 at the time of service.

_____**INSURANCE CLAIMS:** I authorize Bonnie K. Shinhearl to file claims with my insurance company and to release any treatment information that would be necessary to process your claims.

_____**YOUR COVERAGE**: when you use your health insurance plan to pay for mental health services, you agree to work with your insurance company to ensure that payment is made In full. You are responsible for understanding the details of your coverage. You are responsible for payment in full for all services not reimbursed by your insurance company.

_____**MENTAL HEALTH DIAGNOSIS:** Insurance companies require that mental health providers give clients a mental health diagnosis. A diagnosis is required because insurance companies will only provide coverage for services that they deem to be medically necessary. I will discuss your diagnosis with you and answer any questions you may have

_____**TREATMENT AGREEMENT**: I have received a copy of the treatment agreement.

_____**HIPPA.** I have reviewed and received a copy of the Health Insurance Portability and Accountability Act guidelines.

_____**NOTICE OF PRIVACY PRACTICES:** I have received a copy Of these privacy rights and authorize treatment.

TREATMENT AGREEMENT

I agree to the following by signing below that:

1. I authorize Bonnie K. Shinhearl, LLC to file insurance claims on my behalf and to release treatment information necessary to process claims.
2. My treatment is solely with my clinician and not with any other clinician/provider in this practice or with an insurance company.
3. I have received a copy of the privacy rights and authorize treatment.
4. **Payment fees are your responsibility when insurance does not cover visits for the following reasons:**
    - **a.** Pre-authorization has not been obtained
    - **b.** Incorrect/inadequate information about self or insurance company was provided
    - **c.** Services that are not covered by my insurance, i.e. report writing, record fees, phone calls.
    - **d.** Deductibles have not been met.
    - **e.** I will confirm that my insurance covers services with my therapist. I may need to obtain an authorization from the insurance company
    - **f.** **24-hour notice is required for appointment cancellation to avoid a late fee and for missed sessions. This fee is not covered by insurance and is the guarantor's responsibility. Fees for missed appointments is $30.00**

FINANCIAL POLICY

Co-payments: To be paid prior to sessions. Cash, check, HAS, Credit Card

Letters: Written letters will have a minimum fee of $15.00. Case conceptualization/narrative reports will have a fee range of $50.00 to $100.00. Payment is to be made before the letter is written or sent to the recipient. This is not covered by your insurance. **COURT PER DIEM FEE: $600.00**

Telephone Contact: Phone calls with your therapist may incur a charge. This is not covered by your insurance.

Late Cancellations/No-Show Charge: $30.00 late fee for missed/late cancelled appointments. This is not covered by your insurance.

PLEASE INITIAL AND SIGN BELOW

_____I have read and understand and agree to this treatment agreement

PRINT NAME_____

SIGNATURE_____DATE_____

BONNIE K. SHINHEARL, M.Ed., LPCC
LICENSED PROFESSIONAL CLINICAL COUNSELOR
COUNSELING BY BONNIE

9853 Johnnycake Ridge Road
Suite 103
Concord, Ohio 44060
Email: COUNSELINGBYBONNIE@YAHOO.COM

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, _____, authorize BONNIE K. SHINHEARL, LPCC to discuss and exchange, in verbal or written form, any relevant information relating to my treatment with the person or institution named below:

Name/Institution Name

Address

Phone Number

For the following reason(s)

_____coordination of care

_____Other:_____

You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for ONE YEAR from the date of last session.

_____ _____

Client/parent/ Legal Guardian Signature Date

PATIENT RIGHTS AND HIPPA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (**HIPPA**)

1. Tell you counselor if you don not understand this authorization and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your provider at the following address: 9853 Johnnycake Ridge Road, Suite 103, Concord, Ohio 44060
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization and you are in a research-related program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office, according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point, your information may no longer be protected by HIPPA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPPA provides special protections to certain medical records known at "psychotherapy notes." All Psychotherapy Notes recorded on any medium (paper, electronic) by a metal health professional must b kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. Psychotherapy notes are defined under HIPPA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescriptions and monitoring; (b) counseling session start and stop times; (c) the modalities and frequencies of treatment furnished; (d) the results of clinical tests; (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
7. In order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Noes must sign this authorization to specifically allow for the release of Psychotherapy Notes. SUCH AUTHORIZATION MUST BE SEPARATE FROM AN AUTHORIZATION TO RELEASE OTHER MEDICAL RECORDS.

I have read and retained a copy of PATIENT RIGHTS AND HIPPA AUTHORIZATIONS _____YES_____NO

SIGNATURE:

NOTICE OF PRIVACY PRACTICES

Confidentiality and Exceptions to Confidentiality. Federal and Ohio law require that issues discussed with a therapist be confidential. The information you reveal will not be discussed by the therapist with anyone, other than the exceptions listed below, without a signed authorization from you.

- **LEGAL**: The release of confidential materials may be legally required of your therapist in the following situations: (1) If your therapist believes you present a clear and substantial risk of imminent serious harm to yourself (suicide) or others (homicide); (2) Suspected child or elder abuse or neglect; (3) Instances where the court subpoenas records; (4) If you file a lawsuit against your counselor; (5) Legally authorized situations for purposes of national security; if you are a member of the military, or if you are under the custody or correctional or law enforcement official.
- **PATIENT RIGHTS**: Your involvement in treatment is confidential. HIPPA provides you with several expanded rights with regard to your medical records and disclosures of protected health information. Please inform this office in writing if I may not contact you at home. I can have written or oral communication with your other health care providers, family members, or others you designate only with your written consent on a separate form specifying what information may be shared. Therapy notes are for the therapist's own use and are designed to assist me in providing you with the best treatment. Insurance companies cannot receive a copy of your psychotherapy notes or require you to release them. (1) You have the right to restrict the release of information to your health plan for services paid in full out of pocket; (2) You may make an amendment to your record if you believe it is incorrect or incomplete. This is done in writing on a separate form and your explanation becomes part of your record; (3) You will be notified if a breach in the security of the PHI has occurred; (4) Questions or complaints about this privacy policy may be addressed with Bonnie L. Shinhearl, LLC.
- **DIVORCING/DIVORCED PARENTS**: For custody related matters, I do not make recommendations related to custody or become involved in custody disputes as this interferes with the therapeutic relationship with the child/children. On a case-by-case basis, I can make statements based on the therapeutic observations, diagnosis and treatment of a child and information presented in sessions to professional parties such as a guardian ad litem, as long as it does not interfere with the therapeutic relationship.

Client/Parent/Guardian Signature_____Date_____