Centers for Hope & Wellness, Inc

The following information is needed to best help you. It is completely confidential.
Please clearly print your response to each question.

Section I: Client Identifying Information

Today's Date: ________________

Name: ____ SSN: _________________________ Date of Birth: _______________

Address: ____ City: __________________________ State: ____ Zip: ____________

Home Phone: _________________ Work Phone: _______________ Cell: ________________ Email: _________________________

If EAP visit, you are the: Employee________ Spouse ________ Dependant ________ Significant Other ________

Relationship Status: Married _______ Single _______ Divorced _______ Widowed _______

Gender: M ____ F _____

Ethnicity: Caucasian ___ African-American ___ Hispanic ___ Native American ___ Asian-Pacific ___ Other: _______________

School: ____ Grade: __________

Section II: Employee Identifying Information (if EAP visit)

Employee Name: ____ Relationship to Client: ____________________

Company Name: ____ Date of Hire: _____________________________

Job Title: ____ Department: _____________________________________

Laborer: _____ Management _____ Administration _____ Work Phone: _____________________________________

Shift: Days _____ Evenings _____ Nights _____ Swing _____ PRN _____

Supervisor: ____ Supervisor's Phone: _________________________________

How did you hear about the EAP? Newsletter ___ Coworker ___ Family Member ___ Self ___ Manager ___
PCP/Dr. ___ Drug Test ___

Is this visit mandated by your supervisor? Yes __ No __ If yes, who is your supervisor?_________________________________

Is your job in jeopardy? Yes __ No __

Is your job/school performance affected? Yes __ No __ If yes, how?

____

____

Current Disciplinary Action: Counseling ___ Written Warning ___ Suspension ___ Termination ___ N/A ___

Section III: Medical History

Name of Primary Care Physician: ____ Phone: ______________________

Please list any significant illnesses, hospitalizations and injuries:

Dates Problem & Treatment

____

____

____

Are you now, or have you in the past, seen a therapist/counselor? Yes __ No __ Please give approximate dates and reasons_________

____

____

Section IV: Description of Presenting Problem

Please state why you decided to come to the counseling:

____

____

____

How long has this been an issue for you? ____

How would you estimate the severity of the problem? (Place "X" on the line below)

|________________________|________________________|________________________|

Mild Moderate Serious Severe

What symptoms are related to this problem? Please check all that apply for you now:

__overeating
__taking drugs
__odd behavior/thoughts
__recent weight loss
__recent weight gain
__social withdrawal
__family emotional problems
__chest pain
__can't fall asleep
__financial problems
__experienced a traumatic event

__ restless
__ depressed mood
__ crying
__ difficulty concentrating
__ low motivation
__ aggressive behavior
__ feelings of worthlessness
__stomach problems
__sleeping too much
__problems with school
__pain

__rapid heart rate
__sweating
__trembling or shaking
__shortness of breath
__muscle tension
__outbursts of temper
__nightmares
__easily distracted
__decreased need for sleep
__housing problems
__drinking alcohol

__compulsive behaviors
__fears/phobias
__anxiety
__vomiting
__distrust
__jumpy
__dizzy or lightheaded
__fatigue/loss of energy
__obsessions
__relationship problems
__ other: ______________

If applicable, please describe any incidents or problems that may have triggered and/or been associated with this problem (e.g., problem with academic program, relationship ending, etc.): ____

____

____

In the past, what has been helpful to you in dealing with this problem? ________________________________

____

____

SECTION V: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	Dosage	M.D. Prescribing	Duration	Helpful (Y/N)

If applicable, amount of caffeinated beverages per day: coffee ________ soda ________ espresso ________ tea ________

If applicable, number of cigarettes smoked per day:________ If applicable, how often do you use marijuana per week?________

Consider a typical week during the past month. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor

= 4 oz. of wine

= 1 oz. of hard alcohol (regular shot glass)

	Su	M	T	W	T	F	Sa
Number of drinks							
Number of hours							

Think of the occasion that you drank the most in the past month. How much did you drink?___________________________________

How many hours did you drink?________________________

If applicable, other substances used ____

Do you use alcohol, prescribed medication or drugs to (check all that apply):
Manage stress? __ To relax? __ To change mood? __ For sleep? __

SECTION VI: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
Mother	_______	____________________________	___________________________	____
Father	_______	____________________________	___________________________	____
Stepfather	_______	____________________________	___________________________	____
Stepmother	_______	____________________________	___________________________	____
Siblings	_______	____________________________	___________________________	____
	_______	____________________________	___________________________	____
	_______	____________________________	___________________________	____

Are your parents divorced? Yes _____ No _____ How old were you when they divorced? __________________________

Have any members of your family had problems with:

drugs _____ alcohol _____ depression _____ anxiety _____ other mental illness _____ diabetes _____ epilepsy _____

Specifically who?

Problem	Who	Current Y / N	Past Y / N

With whom do you live?

Name	Age	Relationship to you	Supportive? Y / N

Among your friends and family, whom do you count on for support? ____

____

Relationships:

If applicable, describe your relationship with your current partner (place an X on the line below).

|______________________|______________ | |

Major Problems Minor problems Satisfactory Very satisfactory

How long have you been in the relationship? ___________________________

Is there anything else you'd like to tell us?

____

____

Disclosure

HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the da-to-day activities and management of Sudsberry & Colgrove Counseling Services, Inc... For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies, as required by law. For example, we are required to report communicable diseases to the state's public health department.

Other Uses. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders on occasions and statements.

Individual Rights

You have certain rights under federal privacy standards. Among these are:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and/or treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

The Duties of Centers for Hope & Wellness, Inc.
We are required by law to maintain privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. Upon request, we will provide you with the most recently revised notice on any office visit.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office staff. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. The law permits us to charge a reasonable, cost-based fee for copying and postage.

Complaints
If you would like to submit a question, comment or complaint about our privacy practices, you can do so by sending a letter to Doug Colgrove, 7517 Beechwood Centre, Suite 300, Avon, Indiana, 46123. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
The Notice is effective on or after January 1, 2011.

Acknowledgement

I have reviewed a copy of the Notice of Privacy Practices for Sudsberry and Colgrove Counseling Services, Inc.

______________________________ ____________________

Signature *Date*

____

Printed Name

______________________________ ____________________

Parent or Legal Guardian's Signature *Date*

____

Parent or Legal Guardian's Printed Name

______________________________ ____________________

Authorized Signature/Witness *Date*

RIGHTS AND RESPONSIBILITIES

Our experience has shown that when the contract terms of the counseling relationship or evaluation process are clear and explicit from the beginning, some common misunderstandings are avoided. Please read carefully and sign at the bottom.

1. You are an integral part of your evaluation and counseling; you have the right to ask questions at any point. You may refuse to participate in any evaluation task; however, an accurate evaluation is better achieved with your cooperation.
2. Questions concerning your therapist's qualifications and experience will always be answered. As well, you may refuse to participate in any intervention, strategy, or behavior suggested by your counselor.
3. Because we are a teaching practice, we may utilize interns from various graduate programs around the state. You may request or refuse services from an intern practicing at our site
4. Counseling is an interactive reciprocal experience. The counselor will always attempt to meet you, the client, where you are psychologically. Your cooperation in the relationship is central to its' success.
5. A referral will be provided based on your need or at your request.

CONFIDENTIALITY:

6. Within certain legal and ethical limits, information revealed by you will be kept strictly confidential and will not be disclosed to another person or agency without your written permission. The limits to this policy are as follows:

- If a court of law issues a subpoena, we are required to provide the information required by subpoena.
- If a court of law has ordered you to participate in counseling or to be evaluated by our staff, the results of the treatment or assessment must be revealed to the court.
- If you threaten physical injury or death to yourself or another person, we must take steps necessary to protect you or other involved individuals. (This includes disclosure to appropriate authorities or relevant individuals).
- If you or your child discloses emotional/physical/sexual abuse of a minor, we are required by law to report this to the local children's protection agency.
- If you were sent here to be evaluated by an attorney, insurance agency, Social Security, or your employer, we must comply with disclosure.

7. You have the right to be informed about policies regarding fees and services.

- Payment is due at time of service.
- Co-payment or deductible will be due after each session, unless we have a contract with your carrier stating no payment is due.
- Fees are based on the type/length of services you receive. You'll also be responsible for charges incurred on your behalf with other professionals/agencies, court appearances, test scoring, interpretation or preparation.
- Clients presenting for intensive treatment are contracted to pay at the beginning of their program. Contracted clients may terminate treatment at any time at their discretion.
- We reserve the right to terminate treatment for non-payment of fees and services provided.
- Unpaid accounts greater than one session will result in suspension of services until payment is received.

8. You have the right to terminate services at any time.
9. If you cancel or do not show for a scheduled appointment and we do not hear from you for 30 days, then it will be assumed that you are no longer under our care.
10. There will be an additional charge for processing forms other than medical insurance (i.e. disability).
11. It is your responsibility to become familiar with your own mental health benefits if you are using insurance, prior to entering into a treatment contract with your counselor. Our staff may be able to provide you with some insurance information but due to the various plans with each carrier and their confidentiality policies, we cannot guarantee the accuracy of information we receive from your carrier.

APPOINTMENTS

Your appointment time is set aside just for you. We look forward to meeting you at your reserved time. If you miss an appointment without notice, this means that another person is not able to use that appointment time.

Unless there are circumstances your counselor and you would define as an illness or emergency, it is our policy to charge a fee when an appointment is not canceled 24 hours in advance, or is missed. **If an appointment is canceled less than 24 hours in advance or is missed, you will be charged $120. Clients who are being assisted by a local church will be charged $60 for a missed or late-canceled appointment. You are allowed 1 missed/late-canceled appointment without charge.**

Our office reserves the right to enforce one or more of the following options:

- You will be charged for the missed appointment (please note that this service charge will not be covered by your insurance).
- Your full session fee will be billed at time of service, and payment is due at that time.
- Termination from our practice will occur if multiple appointments are missed.

I have read and understand my rights and responsibilities.

____ ____________________

Signature of Client Date

____ ____________________

Signature of Client Date