PATIENT INFORMATION:

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____ **Birth Date**: _____ /_____ /_____

(Last) (First) (Middle Initial)

Social Security Number: _____ **Age:** _____ **Gender:** □ **Male** □ **Female**

Address: _____

(Street and Number) (City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No **Cell**: ( )May I leave a message? □ Yes □ No

Please note, messages may include appointment reminders and/or cancellations or testing results.

E-mail: _____ May I email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

How did you hear about us? (Check one) { } Physician { } Yellow Pages { } insurance { } EAP program { } Friend/Relative { } Brochure { } Website { } other:_____Referred by (if any): _____

INSURANCE INFORMATION:

Subscriber I.D. #: _____ Group # _____

Client relationship to insured (please circle one): **Self** **Spouse** **Child** **Other**

Policyholder Name: _____ Employer: _____

Policy Holders Date of Birth: _____ Policy Holders Social Security _____

I authorize payment of medical benefits Colleen Shain, LCSW for professional services. I also authorize the release of any psychiatric, medical or other information including protected health information (PHI), and or medical records necessary to process claims, I also request payment of government benefits to Colleen Shain, LCSW who accepts assignment.

INFORMED CONSENT:

I consent to the use of disclosure of my protected health information by Colleen Shain, LCSW (herein referred to as clinician), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of the said practice. I understand my diagnosis by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. In understand that my clinician is not required to agree to the restrictions that I may request. However, if my clinician agrees to a restriction that I request, the restriction is binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that my clinician has taken action in reliance on this consent.

I understand that my protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of my clinician. The Notice of Privacy Practices also describes my rights as well as the duties with respect to my protected health information.

I understand that if I have asked the therapist to file health insurance claims for me, the therapist will only send the minimum information required to obtain payment from the insurance company. I understand that no information is released to anyone about my treatment nor will the therapist acknowledge that I am a patient here (even to my immediate family or other healthcare providers) without my expressed written consent. If I wish to communicate with anyone about my treatment, I will ask for a release of information form.

I also understand that my clinician, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment

_____ _____

Patient Signature Date

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

AUTHORIZATION FOR DISCLOSURE & COORDINATION OF CARE

For the Patient:

I, _____ who's Date of Birth is _____,

For the Parent/Legal Guardian: ***(Circle one)***

I, _____] who's Date of Birth is _____,

hereby authorize the below clinician and/or practice, to disclose and/or obtain information/records:

FROM CLINICIAN/PRACTICE:	**TO: PHYSICIAN, CLINICAN, PRACTICE, SCHOOL:**
Colleen Shain, LCSW	**Name:** _____
	Street: _____
	City/St/Zip _____

Please release the following information: (check all that apply)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Other_____
_____Other_____
_____Psychotherapy Notes* (*cannot be combined with any other disclosure)

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with your Health Care Provider.

Revocation
I understand that I have a right to revoke this authorization at any time by sending written notification to Colleen Shain, LCSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This authorization is not required as a condition of treatment. Please note that revocation does not affect information released by this authorization prior to revocation, nor information to be released for billing purposes or other purposes according to law.

Expiration
Unless sooner revoked, this authorization expires one year from date signed
1. When services are terminated by either the clinician or the client or
2. When client has made progress and no longer requires services.

Condition:
I further understand that Colleen Shain, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization will prevent me from providing a continuum of care and/or coordinate services with your providers.

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be collected by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____
Signature of Client or Parent/Guardian/Witness (If you are signing as a personal representative, please describe your authority to act for this individual ie: POA)

_____Check here if patient/client refuses to sign authorization

PROFESSIONAL SERVICE AGREEMENT

Thank you for choosing Colleen Shain, LCSW as your psychotherapist. My goal is to provide you with the best service possible so that you can receive hope and healing. I look forward to working with you to improve your life and your relationships.

YOUR RIGHTS & SELF DETERMINATION

Counseling is a relationship between you and your therapist. It can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. Counseling works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the "Welcome Brochure" giving to you during your first visit. You are free to terminate therapy at any time.

IN CASE OF EMERGENCY

Please be advised that this is not a 24 hour crisis facility and we will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. Your nurse practitioner or therapist may not be available to respond to your call. **In the event of an emotional, behavioral or medical crisis call 911 or go to the nearest emergency room. You may also call the 24 hour Suicide Prevention Hotline at 1800-273-TALK**

FINANCIAL AGREEMENT

Insurance Plans: If using your health insurance plan, the copay/coinsurance charge is $_____, which is due at the beginning of each session. If applicable and as a convenience to you, we can bill your insurance company for each session. You are responsible for paying all copayments, co-insurance, deductibles and insurance denials. Any remaining balance unpaid by the insurance company is your responsibility. _____ *(Initials)*

If using EAP benefits, your financial obligation is $00 for _____ sessions from the EAP provider. _____ *(Initials)*

Medicaid: **I understand that I am financially responsible for all services not covered by Medicaid. I agree to inform this office immediately upon loss of Medicaid eligibility. I understand that I am financially response for any service received after loss of Medicaid eligibility._____*(Initials)***

Cash Only: I, _____, agree to pay $____ **cash only sessions** ($150 for intake session, if not using insurance or other arrangement. I understand that I am responsible for all fees, regardless of insurance payment, and agree to a loss of confidentiality for the purpose of collecting fees in court if my bill has an outstanding balance more than 6 months after last session. I understand that court appearances and/or testimony, depositions, or any other court related work I am asked to provide, regardless of who requests it, will be charged at $150 an hour. _____ *(Initials)*

Sliding Fee Scale: Every effort is worked out for a suitable payment plan with each client. This practice asks that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. If a **sliding fee** is offered, you agree to pay $_____ per session. This payment is due at time services are rendered.

Cancellation Policy: We believe that the issues you have bought to counseling are important. As fee for service practice, it is important to keep business practices simple and straight forward so that we may concentrate energies on helping you. We asked that you give a 24 hour notice of cancellation. Failure to cancel within this timeframe will result in a $50 charge for the missed appointment. In order to insure payment for late cancel or no show appointments, you _____ may charge your credit card the amount of $50 if you do not show up for a scheduled appointment, of if you cancel with less than 24 hour's notice. _____ ***(Initials)***

Court/Litigation: Colleen Shain is not a forensic social worker and does not participate in any court proceedings regarding custody, time-sharing or other court matters. I agree to not submit her name as a witness in any such proceeding, or ask that she be subpoenaed. If I do subpoena her, I agree to a $2,500 retainer fee 24 hours in advance as well as $150.00 an hour for court time and travel expenses to and from court. _____Initials.

Evaluations: We do not provide any personal or diagnostic evaluations of any kind or personal health information for the purpose of child custody, legal disputes, public assistance, or determination of disability for the purposes of receiving SSI. The purpose of these services provided herein is specifically "talk therapy" and or/Life Coaching only.

_____ Initials

If applicable, and as a convenience to you, this practice will bill your insurance company for each session. You are responsible for paying all co-payments, co-insurance, deductibles and insurance denials. A remaining balance unpaid by the insurance company is your responsibility _____ ***(Initials)***

I have read, understand and agree to the above policy. I also acknowledge that by signing this Policy I am solely responsible to pay ALL non-covered services charged by this practice regardless of any outside Agreements with other parties and/or Divorce orders. I also understand that I am responsible for all fees, regardless of insurance payment, and agree to a loss of confidentiality for the purpose of collecting fees in court, if I have an outstanding balance for more than 90 days.

Name: (Print) _____

Signature: _____ /Date:_____

Permission to Treat:

I, _____, (PATIENT or the PARENT/GUARDIAN) of
(please circle one)
_____, hereby give permission to Colleen Shain, LCSW to provide evaluation, assessment, psychotherapy and/or counseling services to me. I understand that psychotherapeutic and/or evaluation services are provided effectively and efficiently in the least restrictive environment. I also understand that I can end treatment at any time and I can refuse any suggestions and/or recommendations that my clinician makes. I also understand that while these services may provide significant benefits, it may also pose risks as therapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. I understand that the process of talking about painful memories, can be difficult and can make me feel worse for a time. I understand that due to factors beyond my therapist's control, such benefits and desired outcomes cannot be guaranteed. I further understand that I can discuss this at any time with my therapist if I am feeling worse. I understand that services can be stopped if I do not follow treatment recommendations or if I fail to pay for any of the services that I receive.

Limits of Confidentiality:

I acknowledge Federal and State laws require the release of certain information in certain circumstances, including suspected child abuse, suspected adult abuse, a person who might be considered a danger to themselves, and duty to warn of a threat of violence. I understand that when deemed safe and feasible, I will be contacted before the report is made.

Acknowledgement of Receipt for Notice of Privacy Practices & Professional Disclosure Forms:

I acknowledge receiving a copy and understanding my Client Bill of Rights, HIPPA policies and PHI information.

Emergency Contact Permission:

I hereby give permission to Colleen Shain, LCSW to contact the following individuals when I am not able to be reached or in the event of an emergency:

NAME: _____RELATIONSHIP: _____ Phone #: _____

NAME: _____RELATIONSHIP: _____Phone #: _____

I release the above clinician from any liability arising from or connected with the activities to which these consents relate.

Signature: _____ **Date:** _____

I have read and understand the content of this form and my signature below provides consent to all described above.

TELE-MENTAL HEALTH CONSENT

I _____, (patient or guardian) hereby consent to participate in tele mental health with Colleen Shain, LCSW as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to tele mental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele mental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 502-552-8185 to discuss since we may have to re-schedule.

Patient Signature: _____ **Date:** _____