Holly Springs Counseling Center, PLLC

Katie Schroeder, LCSW

**Client Information Sheet**

**Demographic Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Sex: | M [ ]  F [ ]  |
| Date of Birth: |       | SSN# |       | Marital Status: | Single [ ]  Married [ ]  Other [ ]  |
| Email Address: |       | Okay to leave a message? Yes [ ]  No [ ]  |
| Phone: Daytime |       | Okay to leave a message? Yes [ ]  No [ ]  |
| Cell |       | Okay to leave a message? Yes [ ]  No [ ]  |
| Client Address: |       |
|       |  |
|       |  |
| Employment Status: | Yes [ ]  No [ ]  | Place of Work: |  |
| Responsible Party: |       |  |
| Address: |       |
| Home Phone if Different from client: |       | Work Phone: |       |
| Referred by |       |  |

**Insurance Information**

|  |  |
| --- | --- |
| Insurance Company Name: |       |
| Claims Address: |       |
| Policy Holder Name: |       |
| Policy Holder Address: |       |
| Relationship to Client: | Self [ ]  Spouse [ ]  Parent [ ]  Child [ ]  Other [ ]  |       |
| Are you under your employer’s health plan? | Yes [ ]  No [ ]  |  |
| ID # |       | Group Number: |       |
| Policy Number: |       | Auth. # |       |
| Employer: |       | Date of Birth: |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| For Office Billing Purposes:

|  |  |  |  |
| --- | --- | --- | --- |
| Date of First Visit: |       | DX Code: |       |

 |

**OVER**Holly Springs Counseling Center, PLLC

Katie Schroeder, LCSW

**Client Information Sheet**

**Medical Information**

|  |  |
| --- | --- |
| MD/Psychiatrist: |       |
| Diagnose(s): |       |
| Medication(s) & Dosage: |       |
|  |  |
|  |  |
| Hx/Hospitalizations/… |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Previous therapy/results |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Consent for Treatment**

I, the undersigned have voluntarily applied for and agree to participate in counseling, psychological, and/or psychiatric services. I hereby authorize Katie Schroeder, LCSW to release treatment and psychological information to my primary medical physician and health insurance carrier if necessary. I understand that I am fully responsible for all fees relating to my treatment, that are not covered by my insurance plan, and I further agree to pay my co-payment at the time of each visit.

In the event that I miss an appointment or cancel an appointment with less than 48 hours notification, I understand that I am solely responsible for paying a $60 fee. Furthermore, if I fail to appear for three consecutive scheduled appointments my case will be placed on inactive status.

\*If you need to cancel your appointment, please do so by either email or phone. If via email, do not assume it is canceled **until** you have gotten a confirmation reply from me. I will note the time you sent it and cancel as long as you have given at least 48-hours’ notice in advance of your appointment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |       |  |       |
| Signature: Client/Responsible Party  |  | Relationship to Client/Self  |  | Date |

Holly Springs Counseling Center, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF

"NOTICE.OF PRIVACY PRACTICES"

*You may refuse to sign this acknowledgement*

|  |  |  |
| --- | --- | --- |
| On this date, I, |       | , received a copy of the brief |
| version of Holly Springs Counseling Center, PLLC "Notice of Privacy Practices" about protecting the privacy of my health information. I am aware that I may request the full length "NPP" to review at any time by requesting a copy from any staff member. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |       |
| Signature: Client/Responsible Party  |  |  |  | Date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |       |
| Signature of Witness  |  |  |  | Date |

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ]  Individual refused to sign.

[ ]  Communications barriers prohibited obtaining acknowledgement.

[ ]  An emergency situation prevented us from obtaining acknowledgement.

[ ]  Other (Specify)

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| --- | --- |
| Holly Springs Counseling Center, PLLC |  |

 **Contract Provider Disclaimer**

**Holly Springs Counseling Center PLLC is composed of Independent Providers who render care and treatment to their clients at Holly Springs Counseling Center PLLC.**

**Your therapy/service will be managed by the Independent Providers who are not employees of Holly Springs Counseling Center PLLC but rent space and provide services for clients at Holly Springs Counseling Center PLLC.**

**Each Independent Provider is solely responsible to maintain individual liability insurance. Please note that the foregoing disclaimer applies not only to therapies performed by Independent Providers, but also to any other claims, damages, or liabilities you may have out of your dealings with your Independent Provider.**

**The Providers at Holly Springs Counseling Center PLLC are solely responsible for judgments and related treatments. Holly Springs Counseling Center PLLC is not liable for any act or omission, including negligence, committed by any Independent Provider, or program run by any Independent Provider at Holly Springs Counseling Center PLLC. Holly Springs Counseling Center PLLC shall not be held liable for services performed by these Independent Providers.**

**Upon signing this form, I acknowledge that I have read and understood the foregoing and accept its terms.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |       |
| **Signature: Client/Responsible Party**  |  |  |  | **Date** |

Holly Springs Counseling Center, PLLC

KINDLY PLAN TO YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICE. THANK YOU.

|  |  |  |
| --- | --- | --- |
| I, |       | , agree to pay my co-payment, deductible, co-insurance, and  |
|  | any past-due balance on my account at the time of service |

I would like to keep a credit or debit card on file that will be automatically billed at the end of each session:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Type of Card:** | DEBIT [ ]  VISA [ ]  MasterCard [ ]  Other [ ]   |       | **Three digit code on the back:** |     |
|  | **Card #** |       | **Expiration Date:** |       |
|  | **Name on Card:** |       | **Zip Code:** |       |

I authorize Holly Springs Counseling Services, PLLC to charge any past due balances on my account to the above debit or credit card number on a monthly basis.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |       |
| Signature: Client/Responsible Party  |  |  |  | Date |

**(Note: This sheet is for your records. You do not need to bring with you.)**

**NOTICE.OF PRIVACY PRACTICES – Brief Version**

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.

***Our Commitment to Your Privacy***

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices ("NPP") and you may have a copy of this to read and refer to it for more information.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a consent form to let us use and share your information in an appropriate manner. If you do not consent and sign this form, we cannot treat you.

If you or we want to use or disclose (send, share, or release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

There are other situations like these but which do not occur very often. They are fully described in the longer version of the NPP.

***Your Rights Regarding Your Health Information***

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you such as your medical and billing records, with the exception of psychotherapy notes made by your therapist. You can even get a copy of these records but we may charge you.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make changes to (or amend) your health information. You have to make this request in writing. Please provide the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with Holly Springs Counseling Center and with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. Filing a complaint will not change the health care we provide to you in any way.

The effective date of this notice is September 1, 2010 (the opening date of business).

Also, you may have other rights, which are granted to you by the laws of our state, and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

*Last updated 20100929*