Anne Danner, LPC
2944 Blackwood Road, Decatur, GA 30033
Phone: (404) 281-6412 Fax: (404) 634-0800 Email: anne@psychotherapyatl.com

INFORMATION PACKET FOR NEW CLIENTS

Welcome to my practice. This packet contains the following forms:

1. *Intake Form* – this is a standard intake form and needs to be completed before we meet.
2. *Client Services Agreement* – this is a form you may keep. It discusses how I run my practice and may answer some preliminary kinds of questions you have.
3. *Georgia Notice Form* – this is the privacy policy information (HIPAA) required by the federal government. You may take a copy of this for your records.
4. *HCFA 1500 Form* – this is a form that provides me with a "Signature on File" so that I may file your insurance claims. (This will not be included if you have indicated to me that you will not be using insurance to help pay for your sessions.)
5. *Insurance Company Form* -- this is a form required by your specific insurance company. (This will not be included if you have indicated to me that you will not be using insurance to help pay for your sessions or if you are a Blue Cross/Blue Shield member.)
6. *Release of Information Form* – this is a form that has to be completed if you would like me to talk (without your being present) to family (including spouse or partner), friends or other professionals. Please see me if you need this form.

If you finish all the forms before I come to get you, please feel free to make yourself at home. Restrooms, coffee and tea are around the corner to the right. Help yourself!

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CLIENT INFORMATION

Last:	First:	Middle:	Marital Status: ☐ S ☐ M ☐ D ☐ Sep ☐ W
Home Phone:	Cell Phone:	Work Phone:	
Birth Date:	Age:	Sex: ☐ M ☐ F	Social Security Number:
Street Address:		Apartment:	
City:	State:	Zip:	Email:
Occupation:	Employer:		

How did you hear about the practice?	☐ MD	☐ Insurance Plan	☐ Hospital	☐ Family/Friend	☐ Web Search	☐ Other

INSURANCE INFORMATION

(Please fill out marked areas of HCFA 1500 form if you will be using insurance to help pay for services.)

BIOPSYCHOSOCIAL HISTORY

Goals for Treatment

Risk Assessment

Are you suicidal?	☐ Yes	☐ No	If "Yes" ☐ Thoughts ☐ Plan ☐ Gesture ☐ Previous Attempts
Are you homicidal?	☐ Yes	☐ No	If "Yes", name/number of the person you are wanting to harm:
Do you self-injure?	☐ Yes	☐ No	If "Yes", please describe:
Aggressive behavior?	☐ Yes	☐ No	If "Yes", please describe:

Treatment

Previous	☐ Yes	☐ No	If "Yes", when and where:
Current	☐ Yes	☐ No	If "Yes", when and where:

Psychosocial Stressors	☐ Recent Death	☐ Work/School	☐ Separation/Divorce	☐ Financial	☐ Legal	☐ Physical Health
	☐ Parenting	☐ Relationship Conflicts	☐ Other			

Symptoms and Behaviors

Hallucinations	☐ Yes	☐ No	If "Yes", ☐ Auditory ☐ Visual ☐ Tactile	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Paranoia	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Delusions	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Mania	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Depressed Mood	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Appetite Disturbances	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Sleep Disturbances	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Change in Energy Level	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Decreased Concentration	☐ Yes	☐ No	If "Yes", circle severity:	Low ← 1 2 3 4 5 6 7 8 9 10 → High
Disorganized/Disoriented	☐ Yes	☐ No	If "Yes", please describe:	

Symptom	Yes	No	Details
Worthless/Helpless Feelings	☐ Yes	☐ No	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Anxiety/Panic Attacks	☐ Yes	☐ No	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Obsessions/Compulsions	☐ Yes	☐ No	If "Yes", please describe:
Phobias	☐ Yes	☐ No	If "Yes", please describe:
Social Withdrawal	☐ Yes	☐ No	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Distractibility/Impulsivity	☐ Yes	☐ No	If "Yes", please describe:
Lying/Manipulative	☐ Yes	☐ No	If "Yes", please describe:
Bingeing/Purging	☐ Yes	☐ No	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Medical Complications/Pain	☐ Yes	☐ No	If "Yes", please describe:
Stealing	☐ Yes	☐ No	If "Yes", please describe:
Sexual Acting Out	☐ Yes	☐ No	If "Yes", please describe:
Truancy/Absenteeism	☐ Yes	☐ No	If "Yes", how often/how long:
Hyperactivity	☐ Yes	☐ No	If "Yes", please describe:
Oppositional Behavior	☐ Yes	☐ No	If "Yes", please describe:
Fire Setting	☐ Yes	☐ No	If "Yes", please describe:
Running Away	☐ Yes	☐ No	If "Yes", how often/how long:
Cruelty to Animals	☐ Yes	☐ No	If "Yes", please describe:
Property Destruction	☐ Yes	☐ No	If "Yes", please describe:
Learning Problem	☐ Yes	☐ No	If "Yes", please describe:

Substance Use

Question	Yes	No
Are you currently using alcohol or other drugs?	☐ Yes	☐ No
Have you ever felt you ought to cut down on your drinking/drug use?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking/drug use?	☐ Yes	☐ No
Have you ever felt bad or guilty about your drinking/drug use?	☐ Yes	☐ No
Have you ever had a drink/drugs first thing in the morning to steady your nerves, get rid of a hangover or get the day started?	☐ Yes	☐ No

Social Support	☐ Adequate Amount	☐ Inadequate Amount

Abuse History

Physical (Include Domestic Violence): ☐ Past ☐ Current	Emotional: ☐ Past ☐ Current	Sexual: ☐ Past ☐ Current

Current Psychiatric Medications

Name	Dose	How Often

SIGNATURES

Please note that there are three places below for you to sign. The first details your financial responsibilities.
The second indicates that you were given or shown a copy of the Georgia Notice Form (HIPAA privacy policy).
The third indicates that you have read the "Client Services Agreement" and agree to its terms.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Anne Danner, LPC, or my insurance company to release any information required to process my claims.

Client/Guardian Signature: *Date:*

I was given or shown a copy of the Georgia Notice Form.

Client/Guardian Signature: *Date:*

I have read Client Services Agreement and agree to its terms.

Client/Guardian Signature: *Date:*

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CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

I have always placed high importance on protecting the privacy of my clients, so there is little that I've had to change to come into compliance with the new laws. However, one change is that HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.

When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have incurred.

Psychotherapy Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client and the particular issues you want to address. In order for the therapy to be most successful, you may have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to less conflictual relationships, solutions to specific problems and significant reductions in feelings of distress. There are, unfortunately, no guarantees or predictions of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might involve, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy; so you be very careful about the therapist you select. If you have questions about my interventions or anything else that happens in our sessions, please discuss them with me whenever they arise. If you ever have doubts about our work, I'd be happy to talk to you about setting up a consultation with another therapist, or, if you prefer, give you some names of therapists you can consult on your own for a second opinion.

Cancellations/Reschedules

I understand that occasionally circumstances beyond your control may arise which would prevent you from attending a scheduled appointment. For this reason, I don't charge for the first missed session (**i.e., less than 24 hours cancellation notice**). You will be expected to pay for any other sessions that are cancelled within the 24-hour cancellation period. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so you will be expected to pay the entire fee, not just the co-insurance amount you might normally pay**. If it is possible, I will try to find another time to reschedule the appointment. However, you would still be responsible for payment for the missed appointment. In a few circumstances, I may work out different financial policies with you. If so, I will discuss this with you before instituting the new policy.

**** Please do not cancel appointments via email. Please leave a message on my voice mail.**

Meetings/Sessions

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

Professional Fees

I am currently an in-network provider for all Blue Cross/Blue Shield policies, Aetna, TriCare, United Behavioral Health and Medicaid (Cenpatico/Peachstate Health Plan and Amerigroup). I will be on the Magellan panel soon. Please know that other insurance companies sometimes use UBH for their behavioral health coverage. Also, please know that some insurance companies offer very reasonable out-of-network benefits.

I will consider a siding scale fee based on insurance benefits and individual circumstances. For those not using insurance, the initial visit charge is $125.00 and subsequent visits are $90.00.

In addition to weekly appointments, I charge this amount ($125.00/$90.00) for other professional services you may need, though I will pro rate the hourly cost if I work for periods of less than one hour. Examples of other services might include report writing, telephone conversations lasting longer than 10 minutes, preparation of records or treatment summaries and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceeding.

Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

Although this has never become necessary in my practice, if your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This could involve hiring a collection agency or going through small claims court which would require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided and the amount due. If such legal action becomes necessary, its costs may be included in the claim.

Insurance Reimbursements

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Because of the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide the company with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or, in rare cases, copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information database. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Contacting Me

My telephone (404-281-6412) is answered by a confidential voice mail that I monitor frequently. Unless I am out of town, I return calls throughout the day, including evenings and weekends. Even though you may have to wait a few hours to hear from me, I will make every effort to return your call on the same day you make it unless your call comes in very late in the evening. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, please contact your family physician or the nearest emergency room or mental health crisis center. If I will be unavailable for an extended time, I will provide you with the name of a colleague/crisis hotline to contact, if necessary.

I am also available by email. **Please be aware that I cannot guarantee confidentiality via any communication on the web.**

Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- ✓ I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- ✓ Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- ✓ If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- ✓ If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the counselor-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- ✓ If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- ✓ If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- ✓ If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are very unusual in my practice.

- ✓ If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services. Once such a report is filed, I may be required to provide additional information.
- ✓ If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to the Department of Family and Children Services. Once such a report is filed, I may be required to provide additional information.
- ✓ If I determine that a client presents a serious danger of violence to another, I am required to make a "duty to warn" call to the person who may be harmed. These actions may also include contacting the police and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. My fee for copying a Clinical Record is $1.00 per page. If I need to refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes on your case. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they generally consist of rather cryptic notes to me about our work that would not be very meaningful to others. They may also contain particularly sensitive information that you or others reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. I've never been asked to release copies of my Psychotherapy Notes, and in most cases, would refuse to do so unless mandated by law, so this information remains highly protected and confidential. Insurance companies cannot require you to authorize me to release my Psychotherapy Notes as a condition of coverage nor penalize you in any way for your refusal to provide it.

Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents

Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

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GEORGIA NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- ✓ "PHI" refers to information in your health record that could identify you.
- ✓ "Treatment, Payment and Health Care Operations"
  - ✓ Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - ✓ Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ✓ Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- ✓ "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- ✓ "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. As a general rule, I do not release my personal Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, couple's, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke the authorization for release of your PHI at any time, provided the revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- ✓ Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- ✓ Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- ✓ Health Oversight Activities – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.

- ✓ Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- ✓ Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- ✓ Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Counselors' Duties

Patient's Rights:

- ✓ Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- ✓ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will not leave messages for you on your home answering machine, as long as I have an alternative way of contacting you.)

- ✓ Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- ✓ Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- ✓ Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- ✓ Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Licensed Professional Counselors' Duties:

- ✓ I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- ✓ I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- ✓ If I revise my policies and procedures, I will discuss these changes with you during a session.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me (Anne Danner, LPC at 404-281-6412).

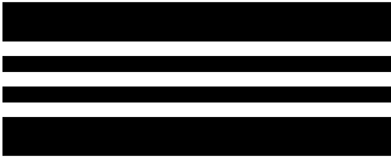
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on April 14, 2003.

I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that I maintain. If this should occur, I will provide you with a revised notice.

PLEASE DO NOT STAPLE IN THIS AREA



APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ________________ DATE ________

SIGN HERE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ________________

SIGN HERE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __ 3. ___ . __

2. ___ . __ 4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

ALERT®

Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name ____ , First Name ____ Date of Birth: (mm/dd/yy) __ / __ / __

Subscriber ID ____ Authorization # ____

Clinician Last Name ____ , First Name ____ Today's Date: (mm/dd/yy) __ / __ / __

Clinician ID/Tax ID ____ Clinician Phone ___ ___ - ____ State __ *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ____ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ____ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ____ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No