Adult Client Packet

Please download and print the following pages.

Please **do not email** the completed packet to us.

Mail the completed packet to:

Yellow Springs Psychological Center
1310 Rice Road
Yellow Spring, OH 45387

If you have questions about the material, please call 937-767-9490/

YELLOW SPRINGS PSYCHOLOGICAL CENTER
New Client Information Form

Client Name

Address

City **Zip**

Phone(h) **Phone(w)** **Phone(c)**

Date of Birth **Age:** **Gender:**

PAYMENT IS DUE AT THE TIME OF SERVICE

☐ Check box if you would like a monthly statement sent to you.

Please provide your email address ***only*** if you would like your monthly statements via email:

Email address:

Signature **Date**

We can securely store your credit card information.
Your card will be charged immediately after a session.

Card #_____

Expiration Date_____ 3 or 4 digit Security Code_____

For Office Use Only

Therapist **Referred by**

Fee $

Yellow Springs Psychological Center ~ 937-767-7044

ADMINISTRATIVE POLICIES

SERVICES

We are providing psychological psychotherapy which is a process that fosters change and growth in the context of a supportive yet challenging interpersonal relationship with a therapist.

We believe that self-awareness, self-acceptance, and the immediate experiences in the therapy session are important ingredients in that growth process. While is it impossible to predict the outcome of therapy with certainty, we trust in the inherent capacity of each person to grow and change. Motivated individuals are most likely to benefit. There is, however, always the risk of experiencing uncomfortable feelings like sadness or anxiety and psychotherapy may require remembering unpleasant past experiences.

We accept and adhere to the ethical guidelines of our professions as set forth by the American Psychological Association, American Counseling Association and the Ohio State Boards of Psychology and Counseling

FEE & PAYENTS

Individual, couples and family sessions cost **$120** per 45-50 minute session unless otherwise negotiated with the therapist.

Payment is due at the time of service. We accept cash, checks and credit cards. We also have an internet Patient Payment Portal.

Report writing and legal proceedings (including preparation, travel and appearance) costs **$125 per hour and up** as agreed upon with your therapist.

There is a bank charge of **$35** for checks returned due to insufficient funds.

APPOINTMENTS & CANCELLATIONS

Please make, cancel or reschedule appointments directly with your therapist. If you must cancel, please do so at least 24 hours in advance to avoid being charged. If you are ill or if the weather makes driving dangerous, stay home. Please give us as much notice as possible. We regularly charge for ***missed*** appointments.

In case of a clinical emergency call 911 or go to the nearest Emergency Room.

CONFIDENTIALITY

What we discuss in therapy is held in the strictest confidence. This confidentiality is required by codes of ethics, the Health Insurance Portability and Accountability Act (HIPAA) and is

protected under the laws of the State of Ohio for licensed psychologists and those supervised by psychologists.

There are, however, a few exceptions. Your therapist may consult with his or her clinical supervisor or another professional in order to better assist you. Our Office Manager, bound by the same standards of confidentiality, may have limited access to your records for administrative and secretarial purposes. If your fees are paid by an insurance company, certain information, including dates of treatment, diagnosis and treatment plan may need to be furnished to obtain reimbursement. We routinely thank referral sources and may also need to communicate with your primary care physician. If we learn of child or elder abuse or neglect or other serious threats of harm to another person, we may take protective action. And we are ethically permitted to release information to prevent acts of suicide. If you testify about your therapy in a court of law we may be required to testify and we may be compelled to respond to an irrevocable court order. Finally, if you file a complaint or lawsuit against us we may disclose information in our defense.

Please raise any concerns you have about confidentiality and its limits with your therapist.

With these exceptions, what you say to your therapist is legally considered privileged communication. This means that nothing discussed in your psychotherapy sessions will be revealed without your explicit permission.

CLINICAL RECORDS

Clinical records are maintained and, except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy if you request it in writing, signed and dated no more than 60 days prior to our receipt. Because these are professional records and can be misinterpreted by or be upsetting to untrained readers, we recommend you review them only in our presence or have them forwarded to another mental health professional so you can discuss the contents.

In most circumstances we are allowed to charge a copying fee ($1 for the first 10 pages, 50¢ per page for pages 11-50 and 20¢ per page after that.), a $15 record search fee and postage. If we refuse your request for access to your records, you have a right of review which we will discuss upon your request. In addition, HIPAA grants you certain rights regarding your clinical record as detailed in the *HIPAA Notice Form* you received.

I have read, understood and agree to abide by the above policies. I have also received the *HIPAA Notice Form.*

Signature_____ Date_____

Yellow Springs Psychological Center

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, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], 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, and 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 and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, 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 all such authorizations (of PHI or psychotherapy notes) at any time, provided each 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, and the 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, in my professional capacity, I know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to the County Department of Job and Family Services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your persona or legally-appointed representative, 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 believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I am required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. 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. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes 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 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Psychologist's 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 notify you at our next appointment and give you a revised notice form.

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 Bob Barcus, Ph.D., Clinical Director, Yellow Springs Psychological Center, 937-767-7044.

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

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 16, 2003.

Yellow Springs Psychological Center, LLC

Adult History Form **(937) 767-7044**

Name _____

Today's date _____ Date of birth _____ Social Security Number _____

Home Address _____

_____

Business name and address _____

_____

Home phone _____ Business _____ Cell _____

Current Occupation _____ For how long _____

Education completed _____

Military service: Dates _____ Branch _____ Rank _____

Person to contact in emergency: Name _____ Phone _____

What problems or difficulties bring you here at this time?

_____

_____

_____

_____

_____

_____

What do you hope to get out of therapy?

_____

_____

_____

_____

_____

_____

Who referred you to us? _____

MEDICAL HISTORY

Physician's name and address _____

Phone (_____) _____ Have you had a recent physical exam? _____ When? _____

Do you have any physical or medical conditions or allergies? If so, please describe them:

_____

_____

Have you ever been hospitalized for physical, emotional or psychological reasons? If so, please state when and for what reason(s):

_____

_____

Are you currently taking any medication? Please explain.

_____

_____

What alternative treatment approaches are you using to help with your problem? _____

_____

Please describe your current and or past use of the following:

Tobacco _____

Caffeine _____

Alcohol _____

Nonprescription or recreational drugs _____

Have you ever had a problem with drugs or alcohol? _____ Describe _____

_____

Have you ever been in treatment for substance abuse? _____ Describe _____

_____

Do you attend any self help groups or meetings? _____ If so which ones? _____

_____

Have you previously been involved in psychotherapy or counseling? _____ If so, when? _____

With whom? _____ For how long? _____

Your reason for terminating _____

_____

Have you ever had suicidal thoughts or plans? _____ When? _____

Please explain: _____

_____

_____

_____

FAMILY BACKGROUND

Parents' names _____ Age _____ Occupation _____

_____ Age _____ Occupation _____

If either is deceased please give YOUR age when they died _____ Their cause of death _____

Are your parents ☐ Married? ☐ Separated? ☐ Divorced? ☐ Remarried? ☐ Never Married?

Where do they live? _____

How often do you see them? _____

Please list your brothers and sisters in order of birth:

Name	Age	Education	Occupation	Health	Marital Status

Your religious upbringing _____

Your present religious affiliation, if any _____

Is there any history of mental illness in your family? _____

Please describe your home life in your family of origin. Include your relationships with your parents and siblings, any traumatic events that took place, and any significant psychological problems family members have had.

_____

_____

_____

_____

_____

_____

Have you ever been the victim of physical or sexual abuse? _____ If so, please explain _____

_____

_____

_____

_____

_____

RELATIONSHIPS

Are You ❑ Single ❑ Married ❑ Living with a significant other How Long?_____

❑ Intimately involved in a committed relationship How Long?_____ ❑ Separated How Long?_____

❑ Divorced How Long?_____ ❑ Remarried How Many Times?_____

Do you have any children ? _____ Please list below their names, ages and gender:

Please describe your marriage or significant intimate relationships.

Please describe your social life.

Is your sexual life satisfactory?_____ Please discuss any problems or concerns you have of a sexual nature.

Have you ever been in trouble with the law?_____ If so, please explain.

Are you currently involved in any pending legal issues? (e.g. divorce, custody, lawsuits or criminal cases). If so, please explain.

Thank you for providing this information.