ROCHE COUNSELING SERVICES

"Where Helpful Conversations Make The Difference"

PERSONAL AND FAMILY RECORD

Client Name_____ Date_____
Address_____City_____State____Zip_____
Phone (Home)_____ (Cell)_____ Best time to call_____
Sex: ___ Age_____ Birth date _____
Employer _____ How long? _____ Position_____
Previous Type of Work History _____
Education: Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Other_____

Marital Status: Single____ never married_____ Engaged_____ Living together without marriage_____
Married_____ Separated_____ Divorced _____ Widow/er? _____
Spouse/Partner name_____Age_____Occupation_____
How long married/in committed relationship?_____ Number prior marriages for you_____

Children	Age	Sex	Relationship to you	Live in your home?
_____	___	___	_____	_____
_____	___	___	_____	_____
_____	___	___	_____	_____
_____	___	___	_____	_____

PRIMARY REASON(S) FOR SEEKING COUNSELING: Briefly state the problem(s) as you see it: _____
_____
_____

How long have you experienced this problem(s), or when did you first notice it? _____
What do you hope to gain from counseling? _____
_____

MENTAL HEALTH AND COUNSELING HISTORY:

Have you ever been to counseling for any reason? Yes_____ No_____ How long ?_____
What reason?_____ Counselor's Name_____

Have you ever been hospitalized for mental illness? Yes_____ No_____
If Yes, for what reason? _____ How long in treatment? _____
Did you continue with outpatient counseling? Yes_____ No _____ Name of Counselor_____

Are you presently working with any other Counselor, Psychologist, or Psychiatrist? Yes_____ No_____
For what reason?_____
Counselor/Psychologist/Psychiatrist's name_____
Are you involved in any other counseling or support groups? Yes____ No____ Specify_____

Who referred you to this counseling office? _____

Do you want to integrate a faith-based perspective in counseling? [ ] Yes [ ] No

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MEDICAL INFORMATION

Family Physician_____Psychiatrist/Psychologist_____

Describe your physical health? excellent_____ good_____ adequate_____ poor_____

Are you taking any prescription drugs? Yes____ No____ If yes, state the drug name(s), type and for what purpose_____
Who prescribed the drug(s)? _____How often do you see this doctor?_____

Are you taking prescription drugs for emotional distress? Yes_____ No_____ If yes, state the drug(s) name_____
Who prescribed the drug(s)_____How often do you see this doctor?_____

IMPACT OF LIFE CIRCUMSTANCES

Circle any LOSSES that you have experienced:

Death of: Spouse, Child, Father, Mother, Sister, Brother, Grandmother, Grandfather, Friend, Pet.
Divorce Separation Broken engagement Miscarriage Abortion Infertility Bankruptcy Homelessness
Career/Job loss Other:_____

Circle any VICTIMIZATIONS or PAINFUL EXPERIENCES in your life:

Child abuse: Physical, Emotional, Sexual, Incest.
Domestic Violence: Physical, Emotional, Sexual.
Abandonment Rape Robbery Assault Suicide Attempt Auto or Industrial accident Major illness
Major surgery Physical disability Chronic pain Other:_____

Circle any PROBLEMS that concern you now:

Relationship(s) with: Spouse Child(ren) Parents In-laws Co-Workers Friends Teachers
Alcohol Street drugs Prescription Drugs Binge Eating Excessive Dieting Or Exercise Shopping Career
Work Too Much Procrastination Communication Depression Anger Grief Gender Identity Sex
Loneliness Mood swings Self-esteem Codependency Stress Fear Anxiety Feelings About Church
Feelings about God Other: _____

INTENSE EMOTIONAL DISTRESS

Current Situation	Explanation
Suicidal thoughts, plans, attempts	_____
Homicidal thoughts, plans, attempts	_____
Desire to cause pain to self or others	_____
In fear for your life or personal safety	_____
Too depressed to care for self or family	_____

In signing below, I affirm that the information given on this form is true and complete.

_____Date_____

Client's Name

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_____	___	___	_____	_____
_____	___	___	_____	_____
_____	___	___	_____	_____

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Major surgery Physical disability Chronic pain Other:_____

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INFORMED CONSENT

WELCOME! Thank you for choosing us as your mental health provider. We are committed to your treatment being successful. We understand that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies and your rights. If you have further questions or concerns, please ask and we will try our best to give you all the information you need.

Deciding to come in for counseling is a big step for many people. We recognize the courage and determination it takes to decide to deal with the situations you are facing. Because counseling depends on honest, two-way communication, we want to explain what you can expect from us, as well as what we will expect of you, while you work together with us at Roche Counseling Services.

May We Contact You?

We may need to contact you regarding scheduling or other issues. What telephone number(s) and Email Addresses may be used?

Phone 1_____ (home/work/cell/other)_____

Phone 2_____ (home/work/cell/other)_____

Email Addresses: _____ _____

May we leave a brief confidential message? Yes No

If yes, please indicate where_____ (e.g. voice mail, answering machine, person, email address)

Emergencies

1 Roche Counseling Services does not have staff to provide 24-hour crisis/emergency intervention- You may not be able to reach your counselor directly in time of emergency.

2 If you are experiencing a life-threatening emergency (e.g. feeling suicidal, assaulted,) dial 911 or go to your local emergency room immediately.

Confidentiality and Release of Information We place a high value on the confidentiality of the information that our clients share with us. Our policy is: All therapeutic communications (including phone calls, emails, and texts), records and contacts with Roche Counseling Services professional and support staff will be held in the strictest of confidence. Information may be released, in accordance with state law, only when

1 The client signs a written release of information indicating informed consent to such release;

2 The client elects to use insurance, managed care organizations, or other third-party payers;

3 The client expresses serious intent to harm him/herself or someone else;

4 There is evidence or reasonable suspicion of abuse against a minor child, elder person 65 years or older or dependent adult;

5 A court order is received directing the disclosure of information.

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It is our policy to assert (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible barring an emergency, before mandated/requested disclosure in the event of #2, #3 or #4. Although we cannot guarantee it, we will endeavor to apprise clients of all mandated disclosures. We also ask that you respect other client's rights to confidentiality. Please do not discuss or disclose any information regarding another client you may know and see in our offices, to anyone outside of this agency. Such disclosure may jeopardize the safety and well being of that person or other family member(s). If such disclosure occurs, you may be faced with legal action from that party. If you are concerned about another client, please speak with a staff member.

Financial Policy

FEES FOR COUNSELING:

Our policy requires payment AT THE TIME OF SERVICE. We offer services to clients who do not have insurance and those who do. If you do not have insurance and need assistance in obtaining counseling services, assistance from individuals and churches may be available and is considered on an individual basis. THIS MUST BE ARRANGED PRIOR TO YOUR COUNSELING SESSION. Otherwise, full payment is expected. The charge for each counseling session is $95.00, due at the time of service.

INSURANCE: MOST INSURANCE COMPANIES REQUIRE THAT YOU GET **PRE-AUTHORIZATION** BEFORE YOU CAN USE YOUR MENTAL HEALTH BENEFITS. PLEASE CALL YOUR INSURANCE COMPANY BEFORE YOU COME AND SEE US. ASK ABOUT USING YOUR "**MENTAL HEALTH BENEFITS**" AND IF YOU NEED PRE-AUTHORIZATION. THEN GIVE US A CALL WITH THE INFORMATION YOU ARE GIVEN. We require that you pay your co-pay or deductible at the time of service. *If your insurance does not pay your account you are responsible for the balance.* Our agreement is with you, not your insurance company. Although we submit claims to your insurance company, **you are ultimately responsible for payment for the services you receive**. Payment to our office is not contingent or dependent upon your insurance carrier.

If you decide to submit a claim to your insurance carrier (other than with those whom we participate), you are responsible for submitting all paperwork to the insurance company. Our office will be glad to help in putting together this paperwork. Full payment must be made to Roche Counseling Services at the time of service. At times, after a claim has been submitted to an insurance company, they may contact our office to obtain information about the diagnosis, treatment plan and licensure of the counselors. If you submit a claim for Mental Health care provided by Roche Counseling Services to your insurance carrier and they contact us for more information, you give Roche Counseling Services permission to release any information necessary to file that claim.

CANCELLATIONS AND NO-SHOWS: If you are unable to make a scheduled appointment, and cancel with less than 24 hours notice or if you do not show up for your scheduled appointment time, you could be charged a $45.00 NO SHOW FEE. If you miss three (3) appointments with or without prior notice to the office, you may be discharged from the therapist at their discretion.

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Consent for Treatment

There are risks and benefits, which may occur with counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals; increased academic productivity; and an ability to deal with stress. Taking personal responsibility for working with these issues may lead to greater growth. You, as the client, have the right to know the clinical guidelines used in providing and managing your care. You also have the right to know your counselor's education/training, licensure and clinical specialties. By entering into this counseling arrangement you give consent to be treated by your counselor.

Challenges of Counseling

1 In counseling, you face the challenge of learning things about yourself or your relationships that you may not like or are difficult to deal with at the time. Often, personal growth cannot occur until you confront those issues/struggles that cause you to feel sadness, sorrow, anxiety, pain, etc. Your counselor will be there for support and you learn to embrace these challenges.

2 Your goal will be to distinguish between those things you do and do not have control over in your life and to assess what responsibilities you have. Often times these responsibilities include identifying the choices for change that are required to achieve your goals.

3 There is also the responsibility that your counselor alone may not be sufficient in providing assistance in the areas of your struggle. If this is the case, the counselor will assist you in exploring alternative plans with you.

ACKNOWLEDGEMENT FOR TREATMENT:

I acknowledge that I have read and understand the information described above, and I authorize Roche Counseling Services to provide counseling and for my care. I understand that I may withdraw this consent in writing and terminate treatment at any time.

Print Name _____

Signature _____ Date_____

Print Name _____

Signature _____ Date_____

Sign Only if Applicable: (for related clients)

I/We consent that _____ may be treated as a client by Roche Counseling Services.

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HIPAA Notice of Privacy Practices

This notice describes how Mental Health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information relating to your past, present, and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your counselor, our staff and others beyond our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the counselor's practice, and any other use required by law.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.

Treatment: We will use and disclose your protected health information to provide, coordinate\ or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example your PHI may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health services. For example, obtaining approval for a hospital may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your counselor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, arranging for other business activities. For example, we may disclose your PHI to counseling school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures, (under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500).

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

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You make revoke this authorization at any time in writing except to the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

1) You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

2.) You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your counselor is not required to agree to a restriction that you may request. If your counselor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your counselor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a rebuttal

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provide in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name _____

Signature _____ Date_____

Print Name _____

Signature _____ Date_____