Client Information Form

To be completed by each person participating in therapy

Today's Date ____________

Client Information

Name ____Date of Birth ______/______/______ Age ______

Address ____ City_____________ State ______ Zip_________

Is it ok to receive mail related to your therapy at the above address? ☐ Yes ☐ No

Primary Phone _______________________ Ok to leave message? ☐ Yes ☐ No Ok to text? ☐ Yes ☐ No

Secondary Phone _____________________ Ok to leave message? ☐ Yes ☐ No Ok to text? ☐ Yes ☐ No

Primary Email __________________________________ Ok to receive therapy-related messages? ☐ Yes ☐ No

Current Occupation_________________________________ Employer__________________________________

Religious Affiliation________________________________ Local Congregation, if any______________________

Family/Relationship/Household

Relationship Status (*Circle one*): Single Partnered Married Committed Separated Divorced Widowed Other

Length of Current Relationship_________________ Partner/Spouse's Name____________________________

Partner/Spouse's Age_______ Partner/Spouse's Occupation_______________________________________

Dates of previous marriage(s) or Committed Relationship(s):

____

List other members of your family and/or all others living in your household:

Name	Gender	Age	Relationship to You	Living with you?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Emergency Contact

Name______________________________________ Relationship___________________________

Phone Number____

Address____

Street *City* *State* *Zip*

Health Information

Briefly describe your current reason for seeking help:

____

____

What would you like to happen as result of your time in therapy? ____________________________

____

Have you ever received psychotherapy, counseling, or other treatment for personal, relationship, or family problems?

☐ Yes ☐ No Dates: __________________________

Name of professional *(Doctor, Agency, Pastor, etc.)* _____________________________

Please list all major health concerns for which you are currently being treated: _____________________

____

What medications or other supplements are your currently taking? ____________________________

____

When was your last medical Exam? _____________________ Reason ______________________

Name of Physician ____________________________________

Has anyone in your immediate family ever been diagnosed with a mental illness? ☐ Yes ☐ No

If Yes, please indicate the diagnosis (if known) and your relationship to this person: __________________

____

Has anyone in your family ever attempted or committed suicide? ☐ Yes ☐ No

If yes, please indicate who and when: ____

Please check any of the following that may apply to you:

- ☐ Relationship Difficulties
- ☐ Sexual Struggles/Difficulties
- ☐ Parenting Problems
- ☐ Changes in Appetite
- ☐ Eating Disorders/Body Image
- ☐ Difficulty Concentrating
- ☐ Anxiety/Fear/Worry
- ☐ Feelings of hopelessness or helplessness
- ☐ Loss/Grief
- ☐ Sleep Difficulties
- ☐ Alcohol/Drug Use
- ☐ Loneliness
- ☐ Irritability/Anger
- ☐ Suicidal Thoughts
- ☐ Chronic Pain
- ☐ Stress
- ☐ Difficulties at Work or School
- ☐ Concerns about Faith/God/Spirituality
- ☐ Fatigue/Lack of Energy
- ☐ Overwhelming Feelings of Guilt
- ☐ Low Self-Worth/Self-Esteem
- ☐ Thoughts of Harming others
- ☐ Physical/Verbal/ Emotional/Sexual Abuse
- ☐ Self-Injury
- ☐ Other: ________________ ________________

Anything else you would like me to know about you & your situation: _______________________________

____

____

Referral Information

Is there someone I can thank for referring you to me for counseling? ☐ Yes ☐ No

If yes, who referred you? ____

Is it okay to mention you by name in a thank you note? ☐ Yes ☐ No

If you were not referred by another person, how did you find me? ________________________________

Financial Responsibility

Who is responsible for payment for sessions? ☐ Self ☐ Another Person

If Another Person, Name? ____

Relationship to client? _______________________________________

Billing Address (If different than Client) ____

____

Primary Phone (if different than client) _________________________ ☐ Home ☐ Cell ☐ Work ☐ Other

Secondary Phone (if different than client) _______________________ ☐ Home ☐ Cell ☐ Work ☐ Other

Employer ___________________________________ Job Title/Occupation _______________________

____ ________________

Signature of Client or Legal Guardian Date

Liability, Rights, Risks & Benefits

Risks & Benefits

When entering a therapeutic relationship, you have the right to choose a therapist that best suits your needs. You have the right to know the education, training, and experience of your therapist. If your therapist is under supervision, you have the right to know the name of your therapist's clinical supervisor.
You should consider the risks and benefits of psychotherapy before entering a therapeutic relationship. The counseling relationship requires cooperation in developing a treatment plan, setting goals, and reviewing your progress. The benefits or outcomes of psychotherapy will vary according to therapist and client personalities and presenting concerns. Counseling can increase self-awareness, improve communication, reduce interpersonal and internal conflict, and alter distressing moods. However, during the counseling process, you may also experience unpleasant, disruptive, or uncomfortable feelings. You may discover that some situations cannot be changed to your satisfaction, leaving you with difficult decisions to make. In very rare circumstance, psychotherapy may even make some situations worse. While the benefits of psychotherapy have been demonstrated through research and experience, no specific outcomes can be promised or guaranteed. It is usually desirable to have a closure session of therapy before terminating therapy. However, you have the right to stop counseling at any time. You have the right to ask questions about your therapy or to seek a second opinion from another mental health practitioner at any time. Feel free to discuss any questions or concerns you may have about the therapeutic process with your therapist.

Right to Privacy & Confidentiality

Client records are kept as documentation for third-party payment, if applicable, and as tool for the therapist. The record is not intended for adjudication and efforts to use for this purpose are highly discouraged. Your counseling records are protected by our center's policies, codes of ethics, and state and federal law (as described in the separate disclosure on confidentiality). However, there are some exceptions under which your information may be released:

- **Your written authorization –** You can give your therapist permission to share confidential information.
- **Issues of Safety –** A) If your therapist believes you are in danger of harming yourself or another person, they are obligated to seek appropriate help for you, contact a family member or notify appropriate authorities. B) Also, if you make your therapist aware of or if s/he suspect that a child, an elderly person, or disabled person has been abused or neglected, the law requires that a report be filed with the appropriate government agency.
- **Judge's Orders –** If required by a judge to release records, your therapist will comply. As part of a legal action you may be involved in, you may request your record be released. However, you should consult with an attorney if you are contemplating any litigation to determine whether such a request may be required by court. If a client files a complaint against their therapist, the therapist may disclose relevant information regarding the client in order to defend themselves.

Liability Statement

By covenant & contractual arrangement, Rev. Chris O'Rear, LCPT, manages a psychotherapy practice within the physical location of Belle Meade United Methodist Church. However, no member of the church staff, any member of the church, or any church entity provides any direct or indirect clinical oversight to the therapists operating in the counseling center. The therapists operating in the counseling center are solely responsible for the pastoral care, counseling, and psychotherapy services provided.

Notification of Privacy Rights

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

I. Preamble

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides extremely strong privileged communication protections for conversations between your psychotherapist and you in the context of your established professional relationship with your psychotherapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very carefully defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient him/her self.

HIPAA provides privacy protections about your personal health information, which is called "Protected Health Information" [PHI], which could personally identify you. PHI consists of three components: treatment, payment, and health care operations.

Treatment refers to activities in which I provide, coordinate, or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment means I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

Health Care Operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The use of your protected health information refers to activities my office conducts for scheduling appointments, keeping records and other tasks within my office related to your care. Disclosures refer to activities you authorize which occur outside my office such as sending your protected health information to other parties (e.g. your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

Tennessee requires authorization and consent for treatment, payment, and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment, and health care operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct the administrative steps associated with your care.

Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's school counselor about her eating disorder and what she might do to be of help to your child. Before I talk to that counselor, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-patient in treatment settings, HIPAA

permits keeping separate "psychotherapy notes" separate from the overall "designated medical record". "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you, hence the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modality of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which includes the following: all identifying paperwork you completed when you first started your care here, all billing information, your individualized treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect patients from unintended, potentially harmful use, are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclosure of protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Not Requiring Consent or Authorization

By law, protected health information may be released without your consent or authorization in the following cases:

- Suspected child abuse, physical or sexual
- Elder and domestic abuse
- Health Oversight Activities (i.e. licensing board for counselors in TN)
- Judicial or administrative proceedings (e.g. if you are ordered here by the court)
- Serious threat to Health or Safety (e.g. threat of suicide, "duty to warn" law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Worker Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

IV. Patient’s Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address, so I will send them to another location of your choosing;
- The right to inspect and have a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the record;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your privacy rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointments. My duties on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified.

V. Complaints

I am the appointed "privacy officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have somehow compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. <u>I will not retaliate against you for filing a complaint.</u>

VI. This notice shall go into effect 8/01/2017 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

Receipt of Information & Consent to Therapy

By signing below, I agree that I have received the following information, have read and understand this information, and that I am agreeing to work with my counselor in a therapeutic process under the guidelines and policies outlined in these documents.

_____ Therapist/Practice Information

_____ Notification of Privacy Rights/HIPPA

_____ Liability, Rights, Risks & Benefits

_____ Guidelines & Limitations for Insurance Utilization (if applicable)

I agree to a fee of $________ per 50-minute session of counseling (excluding other fees outlined in the practice information).

____ ____________________
Signature of Client Date

____ ____________________
Signature of Therapist Date