Deborah S. Green-Lauber, LISW-S, Psychotherapist
P: 614-527-4335, www.counselinginhilliard.com, E: deborahg-l@counselinginhilliard.com

Health Insurance/EAP/Private-Pay Form

Client Name:_____DOB:_____Gender _____

Address:_____City:_____ST:____ZIP:_____

Phone:_____ Email:_____ OK to use both for messages ☐

Emergency Contact-Name/phone:_____

Primary Ins. Co. Name:_____Employer:_____

Insured's ID #:_____ Group #:_____Payor ID#:_____

Name (if not ct):_____Rlshp to Ct:_____DOB:_____

Address:_____City:_____ST:____ZIP:_____

EAP Co. : _____ Employer:_____

EAP Employee Name:_____Relationship to Ct:_____DOB:_____

EAP ID#:_____Total # of Sessions Authorized:_____

EAP Authorization #:_____ Dates of Auth:_____to_____

Secondary Insurance Co.:_____Employer:_____

Insured's ID #:_____Group#:_____Payor#:_____

Secondary Insured's Information: (if different than client)

Name:_____Relationship to Ct:_____DOB:_____

Address:_____City:_____ST:____ZIP:_____

Check if using Private-Pay/No Insurance_____

Deborah S. Green-Lauber, LISW-S will bill the above insurance company/ EAP company directly for all services. Your signature indicates liability for any balance due. The client's signature below authorizes release of any necessary medical or other information requested by the insurance company to process the claim. Your signature requests and assigns direct payment to Deborah S. Green-Lauber, LISW-S all proceeds payable under the terms and provisions of your insurance policy.

Signature:_____Date:_____

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Consent for Treatment

I,_____ give consent to Deborah S. Green-Lauber, LISW-S to provide psychotherapy services to me. I understand that information disclosed in clinical sessions is confidential and may not be released to anyone without my written permission. This therapist adheres to professional, legal, and ethical guidelines established by state law. Legal and ethical exceptions to confidentiality include:

1) When there is clear and present danger or harm to you or others.
2) When there is knowledge or suspicion of abuse or neglect of children or elderly persons
3) When a court issues a subpoena for clinical records.
4) When an individual cites their treatment in a legal proceeding. I have also reviewed the information, at www.counselinginhilliard.com, regarding use of PHI per HIPAA.

I understand I have the right to competent and professional service. I have the right to be treated with respect and courtesy, in a therapeutic relationship free of abuse. I have the right to file a complaint. I have the right to my access my clinical record and to authorize the release of the record. I am responsible to be an active, collaborative participant in my therapy process.

Payment: I understand that I am financially responsible for the psychotherapy fees at a private-pay fee of $100 per therapy session. If I choose to use insurance benefits, I am responsible for any unpaid balance not paid by my insurance company.

Missed appointments: I understand I will be charged a late cancel/no show fee of $50, if I fail to give 24 hrs notice to cancel an appointment.

Email Restrictions: I understand that electronic communication-email, voicemail, and fax, may be easily accessed by unauthorized people that may compromise confidentiality. I understand and agree to accept these risks to confidentiality, if I use electronic communications. This office uses a HIPAA-compliant, secure, encrypted, email server- G Suite. If I desire a teletherapy session, I will consult with this therapist. In the event of an emergency during my psychotherapy sessions, I understand this therapist may contact my emergency contact person, listed on my paperwork.

I have read the above information and have had the opportunity to discuss this consent with my therapist. I give full voluntary consent to clinical services rendered by Deborah S. Green-Lauber, LISW-S. I understand that I may terminate clinical services and this consent at any time. My signature signifies understanding and agreement to these policies.

Client Signature_____**Date**_____

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PERSONAL INFORMATION FORM – ADULT

Client Name: _____DOB:_____

Employer:_____ Position: _____ Education level: _____

Who referred You:_____

SYMPTOM CHECK LIST: (check all that apply;)

□ agitated	□ restless	□ anxious	□ racing thoughts
□ fearful	□ worry a lot	□ depressed	□ appetite increase
□ cry often	□ don't fit in	□ confused	□ appetite decrease
□ hopeless	□ helpless	□ sad	□ no appetite
□ withdrawn	□ guilt	□ suicidal	□ overly distracted
□ out of control	□ hear voices	□ personality changes	□ mood swings
□ suspicious	□ can't concentrate	□ overactive/rapid speech	□ homicidal
□ angry	□ irritable	□ passive	

How long have symptoms been present?
□ less than a month □ several months □ several years □ since childhood

SLEEP PATTERNS: (check all that apply)

□ awaken early	□ insomnia	□ hard to get to sleep	□ sleep too much
□ excessive fatigue	□ night terrors	□ sleep walking	□ nightmares

# of hours of sleep per night: _____

ENERGY LEVEL:
□ tire easily □ average energy □ high energy

PRIMARY STRESSORS: (check major areas of stress)

□ Problems with family or friends	□ Not enough support people
□ Death or loss of loved one	□ Educational stressors
□ Occupational stressors	□ Housing problems
□ Economic/ financial problems	□ Transportation problems
□ Legal Issues	□ Other: _____

TREATMENT HISTORY:
List any previous Psychiatric/Med. Management or Psychotherapy/Counseling: □ None
_____

CHEMICAL USE HISTORY:
Do you use Nicotine? □ YES □ NO If yes, how many packs per day? _____
Do you use Caffeine? □ YES □ NO If yes, how much: _____
Do you use alcohol? □ YES □ NO If yes, what type? □ Beer □ Wine □ Liquor
How often do you drink alcohol? □ Daily □ 3-5x/wk □ 1-2x/wk □ Less
Do you use drugs? □YES □ NO If yes, substance used/frequency? _____
Do you or any family members have a problem with alcohol or drugs? _____

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FAMILY HISTORY:

Spouse/Partner's Name: _____ Age: _____ Yrs together:_____

Client's # of Children: _____ Client's # of Siblings: _____

Number in your Household: _____ Names/Ages of People in Your Household:
_____
Have any Family Members Been in Mental Health Treatment? □ YES □ NO

If yes, please specify:
_____
Have you ever been exposed to abusive behavior(s)? □ YES □ NO

If yes, specify if you choose:_____
Anything else you would like your Provider to know?_____

MEDICAL HISTORY:
Primary Care Provider: _____ Phone: _____

MEDICATIONS CURRENLY BEING USED: (prescribed and/ or over-the-counter) □ None

Medication	Dosage	Frequency	Started	Prescribed By

VISUAL □ No Px □ Glasses □ Blindness □Visual Px_____
HEARING □ No Px □ Dizziness □ Hard of Hearing □ Deafness □ Other_____
RESPIRATORY□ No Px □ Asthma □ Congestion □ Breathing Px□ Emphysema
CARDIO □No Px □ High BP □ Chest pain □ Prior stroke □Prior heart attack
EXCRETORY □ No Px □Urinary Px □Bladder Px □Other:_____
NEURO □ No Px □ Seizures □ Migraines □Memory px □Hx of head injury
SEXUAL □ Sexual issues□ PMS □ Menopause □Sexual Orientation _____
ENDOCRINE □ No Px □ Diabetes □ Hypoglycemia □ Thyroid Problem
GASTRO □No Px □ Nausea/vomiting □ Diarrhea □ Ulcers □Constipation
MUSCULO □ No Px □ Muscle px □ Joint pain □ Restricted motion □ Back pain
CANCER □ None □ Type: _____ Year of Discovery: _____
Other Medical Conditions / Surgeries: _____