**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:_______

Emergency Contact-Name/phone:______________________________________________________

OK to leave message ☐ Phone:____________Email:_____________________________________

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_______

We 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 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:_________

# Deborah S. Green-Lauber, LISW-S, Psychotherapist

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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, what do you use? ____________________ How often?____________________-____________
Do you or any family members have a problem with alcohol or drugs? ______________________

**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:_________________________________________________________
Is there 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 | Start of Med. | 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/REPRODUCTIVE Sexual Orientation: ___________________________________________

□ Sex worries □ Birth Control px □ PMS □ Menopause □Other: ________

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: _________________________________________________________

# Psychotherapy Practice of Deborah S. Green-Lauber, LISW-S

## Teletherapy Consent Form

I,______________________ hereby consent to engage in teletherapy with Deborah S. Green-Lauber, LISW-S. Teletherapy is a form of psychotherapy provided via technology-assisted media, which can include consultation, treatment, transfer of medical data, emails, telephone conversations/sessions, using interactive audio, video or data communications. I understand teletherapy involves communication by electronic means between a practitioner and a client, in two different locations.

I understand the following with respect to teletherapy:

1) I, the client, need to be a resident of Ohio and located in Ohio during the session (except under national health crisis).
2) I, understand that I have the right to withdraw consent at any time without affecting my right to future care.
3) I understand that there are risks and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
4) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written or electronic health records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5) I understand that the privacy laws that protect the confidentiality of my (PHI) also apply to teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental health as an issue in a legal proceeding).
6) I understand that teletherapy does not provide emergency services. If I am experiencing a crisis, I can go to my nearest ER. I also understand if I am in crisis, it may be determined that teletherapy services are not appropriate and a higher level of care is required.
7) I understand that during a teletherapy session, we could encounter technical difficulties resulting in service interruptions.
8) I understand there is a risk to being overheard during teletherapy. I am responsible to provide a private place for my teletherapy session.
9) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I understand I need to provide contact and location information prior to our teletherapy sessions.

I have read, understand and agree to the information provided above regarding telehealth.

Client Signature: __________________________________________________________Date:_______________

Therapist Signature: ______________________________________________________Date:_______________