



TEPPER COUNSELING, LLC

**Client Intake
&
Information Packet**

Dear New Client:

Welcome! I am a Licensed Independent Social Worker through the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board with a clinical focus on Mental Health and Substance Use practice.

Please complete this packet of information, and prepare to present your insurance card to copy for our records. If I am in-network for you, **you are responsible for the co-pay** today or during the next billing cycle, and we will file the insurance claim. If you are out of network, you will owe the full fee today, and you are responsible for filing that claim yourself. We will assist in any way possible with this process.

If you do not show for an appointment, and do not call, you will owe a \$75 fee that will be charged to your credit card on file. Please call within a 24 hour time frame to cancel and reschedule or a late cancellation could also result in a \$75 fee as well. I am committed to being on time for your appointment, and hope that you attempt to do the same. If you are 15 minutes late, there is no guarantee that I will be able to fit in a full session. Please call ahead if you see this as a possibility.

Please note that all clients must be physically present in the state of Ohio, regardless of residency, to receive services.

Thank you for starting the counseling process here with me. I look forward to working with you.

Respectfully,

Shauna Tepper, MSW, LISW
(they/she)
shauna@teppercounseling.com
(614) 379-2718



LISW

I understand that I am financially responsible for any balance or copay not covered by my insurance.

Signature of Client, Parent, or Guardian:

Signature

Print Name

Date

1. Introduce Yourself

Name (legal): _____ Date of Birth: _____ Gender(s): _____

Parent/Guardian Name(s) _____ Assigned Sex at Birth : _____

Chosen Name or Nickname: _____ Pronouns: _____

Address: _____ City: _____ Zip Code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Can I Contact you with Calls/Texts/Voicemail (Circle all that apply)?

Email Address: _____ Today's Date: _____

Anything important you would like me to know about you or how you identify?

—

2. Insurance Information

Insurance Company: _____ Group Number: _____

Insurance Holder Name: _____ Insurance Holder Date of Birth: _____

Insurance Holder Employer: _____ Employer Phone: _____

Policy Number: _____

I authorize Shauna Tepper, LISW to release/exchange treatment information with my family physician and health plan's utilization reviewers in order to facilitate my treatment by Shauna Tepper, LISW.

Signature of Client, Parent, or Guardian:

Signature

Print Name

Date

Insured's or Authorized person's signature. I authorize payment of benefits to the undersigned physician or supplier for services provided.

Signature of Client, Parent, or Guardian:

Signature

Print Name

Date

3. Emergency Contact

I authorize the following individuals to assist me during a Mental Health Emergency:

Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form. In the event I am made aware of a Mental Health Emergency or one arises during session I understand my therapist will contact the aforementioned individual(s) to ensure my safety.

Signature of Client, Parent, or Guardian:

Signature	Print Name	Date

4. Scheduling

Authorization for client appointment information:

I Authorize the following individuals to (check all that apply):

- Schedule Appointments
- Cancel Appointments
- Change Appointments
- Inquire about appointment times/dates discuss/handle billing, insurance and payment issues

Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form.

Signature of Client, Parent, or Guardian:

Signature	Print Name	Date

5. Informed Consent for Therapy Services

You are beginning a course of therapy that may be new to you, The following is information that may be helpful to you as you engage in this process.

Services offered: The licensure and credentials held by this therapist provides her the authorization under law to dependently diagnose and treat mental and emotional disorders and all substance related disorders.

Cost of Services: The cost of the sessions are as follows: \$80-110 for an individual session, \$100-120 for the initial assessment session, \$50 for reports needed, and \$120 for an "assessment only" request. If you have out of network coverage under mental health with your insurance, it will be your responsibility to file the claims so that you can be reimbursed. Each insurance company will pay its own usual and customary rate. **Rates of reimbursement will vary.**

** Please note that all returned checks will be subject to a \$25 fee, plus the amount of the check. Payment will need to be made at the time of the request in cash or credit card.

Confidentiality: Information disclosed in clinical sessions is confidential and may not be released to anyone without your written permission. This therapist; Shauna Tepper, LISW adheres to professional, legal, and ethical guidelines established by state law. Legal and ethical exceptions to confidentiality include:

1. When there is a 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 subpoenas clinical records.
4. When an individual cites his/her treatment/clinical record in a legal proceeding.
5. When doing therapy through Google Hangouts Meet, in a telehealth/remote service format, the client understands that confidentiality could be limited depending on where the client chooses to video conference. This therapist commits to being in their work therapy office in private or, should the situation arise, in a private area of the therapist's home.
6. The client understands that regroup.com uses Google Hangouts Meet, which is stated in the regroup research that it is HIPPA compliant and has a BAA.
7. The client understands that the notes that are written for documentation purposes of the session, and all the client's personal information is through the same protected website through therabill.com as it has been for face to face therapy, or, if initial written paperwork

is double locked in the therapist's office by the NASW code of ethics' standards.

Missed Appointment and Cancellation Policy: If you know you are going to have to cancel an appointment, contact this therapist at (614) 379-2718. as soon as possible. If I do not answer, leave a message. Please let me know if you desire to reschedule your appointment and leave a message about dates and times that may work for you. If you do not show and do not call, you will be billed a \$75 fee. The second time, you will be charged the total amount of your fee. If this occurs a third time, a termination of services will be discussed.

**It is important to note that Shauna Tepper does not fill out disability, FMLA or other paperwork related to worker's compensation. If you need Shauna to talk to your physician and collaborate on a report that he/skie will be filling out please let her know,

*If you are going to need Shauna Tepper, LISW to communicate with the courts for a reason related to a substance abuse assessment, a \$50 charge will occur for documents including the assessment and recommendations to be prepared. Releases of information will be gathered for ethical purposes. This can't be billed to your insurance company, and will be required before the documents are prepared and sent.

** If Shauna Tepper, LISW, does not hear from you for a 90 day period of time, a courtesy phone call will be made to check on your desire for continued services. If you do not wish to continue treatment, your chart will be closed at that time.

Your signature below means you have read the enclosed HIPAA form provided and that you have asked questions if necessary, understand the form, and understand its implications.

Your Rights: You have the right to competent and professional service. You have the right to be treated with respect and courtesy. You have a right to a therapeutic relationship without physical, sexual, verbal or other form of abuse or exploitation. You have the right to file a complaint. You have the right to review your clinical file and make a written request to have it released to a competent professional.

Your Responsibilities: You are responsible to be an active, collaborative participant in your therapy process. I have read the above information and have had the opportunity to discuss any questions I might have. I request and voluntarily consent to clinical services rendered by Shauna Tepper, LISW. I understand that I may terminate clinical services and this consent at any time.

Your signature below indicates your agreement to obtain treatment byShauna Tepper, LISW.

Signature of Client, Parent, or Guardian:

Signature

Print Name

Date

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals + + + =
Total score

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
 (Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
 =Total Score:

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tell Me More About Yourself

Reason(s) for engaging in therapy at this time:

What would you like to achieve in our work together?

Have you received counseling in the past? If "yes", please explain the type of counseling you received and what you found most helpful, and least helpful.

Are you currently on any prescription medications? Please list medication, dosage, how long you have been taking the med(s), prescribing physician, and if you feel like it has been working.

Please write your current active doctors including primary care physician and specialists and their phone numbers:

Who in your life is most important to you?

Have you ever been given a mental health diagnosis? If “yes,” please indicate the diagnosis and year given:

Do you need any physical accommodations? If “yes,” please indicate your needs below:

Please tell me about your ethnicity, origin, and racial identity:

Are there any other important ways in which you identify yourself?

Please indicate any family history of mental health diagnoses:

Is there anything else you would like for me to know in order to provide you with the best possible services?

7. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Explanation of Forms: Your social worker, Shauna Tepper, LISW, handles medical and clinical information about you, and law regulates how that information is handled. To comply with the law, Shauna Tepper, LISW asks you to receive this notice and sign an authorization form.

Shauna Tepper, LISW, is allowed by law to use and disclose information about you for the purposes essential to providing care (ie. treatment, payment collection) with your written consent.

An authorization allows Shauna Tepper, LISW to not use and disclose information about you for any other reason than is listed in the authorization. Shauna Tepper, LISW may not refuse to treat you for refusing to sign the authorization. Other rules about your rights regarding medical information are described in this notice.

Types of Uses and Disclosures: Medical information about you may be used or disclosed by this mental health clinician to help facilitate treatment, payment, and health care operations. Treatment includes consultation, diagnosis, provision of care and referrals. Payment includes all those things necessary for billing and collection, such as claims processing. Some examples of disclosures and use are below. This information would only be released with the client's written permission.

Example of Treatment Disclosure: Shauna Tepper, LISW may disclose medical information about you to your treating physician, a hospital or other providers to help them diagnose and treat an illness or injury.

Example of Payment Disclosure: Shauna Tepper, LISW may disclose medical information about you when health plans or insurers, or other payers require information before paying for your health care services.

Other Uses and Disclosures: Your social worker may use or disclose your protected health information in the following situations without your authorization. These situations include:

As required by law: Your counselor may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.

- Abuse or Neglect: Your counselor may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect, In addition, your counselor may disclose your protected health information if she believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- Legal Proceedings: Your counselor may disclose protected health information in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- Law Enforcement: Your counselor may also disclose protected health information, so long as applicable

legal requirements are met, for law enforcement purposes, These law enforcement purposes include: (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the private practice of Jennifer Haywood and (6) medical emergency (not on the premises of the office of Shauna Tepper) and it is likely that a crime has occurred.

- Your counselor may use or disclose your protected health information if you are an inmate of a correctional facility and your counselor created or received your protected health information in the course of providing care to you.
- Criminal Activity; Consistent with applicable federal and state laws, your counselor may disclose your protected health information, if she believes that use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of self, another person or the public. Information necessary to ensure your safety or the safety of others may be disclosed to law-enforcement officers, potential targets of violence or others as required by law. Your counselor may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- Workers' Compensation: Your protected health information may be disclosed by Shauna Tepper as authorized by the client to comply with worker compensation laws and other similar legally established programs.

With your written authorization your social worker may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.

Restrictions: You have the right to request restrictions on the use and disclosure of medical information about you.

Confidentiality: You have the right to have Shauna Tepper, LISW, use only confidential means of communicating with you about clinical information. This means you may have information delivered to you at a certain time or place, or in a manner that keeps your information confidential,
Access- You have the right to see and receive a copy of information about you kept by Shauna Tepper, LISW, under most circumstances,

Amendment: You have the right to have Shauna Tepper, LISW, amend records of information about you. Your counselor may refuse to amend information that is accurate, that was created by someone else, or is not disclosable to you.

Copy: You have the right to receive a paper copy of this notice.

Privacy Notice: Shauna Tepper, LISW, is required by law to keep medical information about you private and to give you this notice. She must abide by this notice; however, your counselor reserves the right to amend this notice and make such change applicable to all clinical/medical information maintained by your counselor.

Effective Date: This notice is effective from October 9th 2020 until revised by Shauna Tepper, LISW.