Client Number **Date of Admission**

Clear View Trauma Therapies, LLC
Intake Form

Last Name **First Name** **Middle Name**

Street Address **City, State, Zip Code**

Home Phone # **Social Security Number** **Referral Source**

Parent's Name **Phone Number**

Legal Guardian (if Different than above) **Phone Number**

Mailing Address **City** **State** **Zip Code**

Date of Birth

Reimbursement status

DCN _____ Insurance _____

CTS _____ Self-pay _____

Signature of person responsible for charges, client, or other:

Name Relationship

Date:_____**Patient Survey-CY 2011**

Please tell us about yourself or, if you are accompanying a patient, the patient who is being *seen today. This information will help us maintain service records of the demographics of the people that CVT may serve. Your cooperation is greatly appreciated and your answers will be held in strictest confidence.
Do not include your name or other identifying information on the survey form.

NOTE: If you have completed this survey during a recent visit, please *do not* complete it again.

1. What is the patient's date of birth? (month/day/year) _____/_____ /_____

2. What is the patient's sex? Male **(1)** Female **(2)**

3. What is the patient's race? (please check one)
Asian **(1)** American Indian or Alaska Native **(2)** Black or African American **(3)** Native Hawaiian or Pacific Islander **(4)** White **(5)** More than one race **(6)**

4. Is the patient Hispanic or Latino? Yes **(1)** No **(2)**

5. Would it be useful for the patient to communicate in a language other than English?
Yes **(1)** No **(2)**

Please check the box next to the number of family members living in the patient's household and then check the appropriate pre-tax income range *to the ri*ght, or circle the column (1, 2 or 3) which corresponds to your household size and pre-tax income.

Family Size	**>>>>>>>>>>Income Range<<<<<<<<<<**		
	(1)	(2)	(3)
1 person	$0 -$10,210	$10,211-$20,420	more than $20,420
2 people	$0 - $13,690	$13,691- $27,380	more than $27,380
3 people	$0 - $17,170	$17,171 - $34,340	more than $34,340
4 people	$0 - $20,650	$20,651 - $41,300	more than $41,300
5 people	$0 - $24,130	$24,131 - $48,260	more than $48,260
6 people	$0 - $27,610	$27,611- $55,220	more than $55,220
7 people	$0 - $31,090	$31,091- $62,180	more than $62,180
8 people	$0 - $34,570	$34,571- $69,140	more than $69,140
9 people	$0 - $38,050	$38,051- $76,100	more than $76,100
10 people	$0 - $41,530	$41,531- $83,060	more than $83,060
11 people	$0 - $45,010	$45,011- $90,020	more than $90,020
12 people	$0 - $48,490	$48,491- $96,980	more than $96,980
13 people	$0 - $51,970	$51,971-$103,940	more than $103,940

If more than 13 people, what is the patient's family size? _____ and income? $_____

6. How will this visit be paid? (check the single largest payment source)

Medicare **(1)** Medicaid **(2)** Other Public Insurance **(3):** _____ **(please specify)** Private Insurance **(4)** Self-pay **(5)**

Please fold this form and put it in the box at the front desk. Thank you.

HIPAA REQUIREMENTS:
NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS DOCUMENT

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
November 19, 2015

The law protects the privacy of communications between a client and a counselor. In most situations, CVT can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA (Health Insurance Portability and Accountability Act of 1996). There are other situations that require only that you provide written advanced consent. Your signature on the Informed Consent Agreement provides consent for those activities as follows.

Use and disclosure of protected health information for the purposes of providing services: Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow CVT to use and disclose your health information for these purposes as follows.

TREATMENT: CVT clinicians may use and disclose health information to

1. Provide, manage, or coordinate care with your physician or other healthcare provider who is also treating you;
2. Ensure that CVT staff are providing the highest quality counseling, we may consult with other mental health providers. During such consultations, CVT makes every effort to avoid revealing the identity of clients. The other professionals are legally bound to keep the information confidential.

COLLECTING PAYMENT: If you would like to attempt to seek reimbursement for counseling from your health insurance provider, I will disclose information to your insurance provider at your request. If you have not paid for services at the time of your appointment as required, CVT may be forced to send you a bill which may include information that identifies the client as well as other healthcare information.

HEALTHCARE OPERATIONS: CVT may have to disclose health information for both clinical and administrative purposes, such as review of treatment procedures, review of business activities, certification, compliance, and licensing activities.

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT:

1. CVT clinicians and staff are mandated to report the following to the appropriate authorities:

    a. If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, CVT may be required to provide additional information;

    b. If CVT clinicians and/or staff have reason to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon them, other than by accidental

means, or has been neglected or exploited, we must report to an agency designated by the Department of Human Resources. Once such a report is filed, we may be required to provide additional information;

c. If CVT clinicians or staff determine that a client represents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary;

d. If CVT clinicians or staff determine that you are a serious threat to yourself, we may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection;

e. If ordered by a court of law. If you are involved in a court proceeding and a request is made for information regarding CVT professional services, such information is protected by the counselor-client privilege law, unless CVT clinicians or staff are ordered to release it by the court. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order CVT to disclose information;

f. if a government agency is requesting information for health oversight activities, CVT may be required to provide it for them;

g. if a client files a complaint or lawsuit against CVT, CVT clinician's, or CVT staff, we may disclose relevant information regarding the client in order to defend ourselves;

h. if a client files a workers' compensation claim, and CVT is providing treatment related to the claim, CVT must, upon appropriate request, furnish copies of all medical reports and bills. Fortunately, these situations are unusual in our practice.

CLIENTS' RIGHTS

1. You have the right to request where CVT and its staff contact you: home, work, cell phone, e-mail, or some other means of your choice.

2. You have the right, by written authorization, to release your medical records to others. You also have the right to revoke that release in writing. Revocation is not valid to the extent that CVT has already acted in reliance on your previous authorization.

3. You have the right to make a written request to inspect and copy your records. You will be charged $0.10 per page for copying in addition to any mailing costs. CVT may, under some circumstances, deny this request.

4. You have the right to make a written request that CVT clinicians or staff amend your records. CVT and its staff will have at least 30 days to decide whether to amend your records as you have requested and in some instances may deny your request. If your request is denied, you have the right to file a disagreement statement. Your disagreement statement and CVT's response will be filed in the record.

5. You have the right to make a written request for an accounting of disclosures made of your health information with the following exceptions: disclosure for treatment, payment, or healthcare operations; disclosures pursuant to a signed release; disclosures made to the client; disclosures for national security or law enforcement purposes.

6. You have the right to make a written request to restrict uses and disclosures of your healthcare information; however, CVT is not obligated to agree to your request. If I do not agree to your

request, you have the right to complain: first to the clinicians or staff member and secondly to the U.S. Department of Health and Human Services. CVT will not retaliate against you for such complaints.

7. You have the right to receive changes in policies.

If you have any questions or concerns about the foregoing, please do not hesitate to ask a staff member, and we will make every attempt to answer them.

Clear View Trauma Therapies, LLC
Conditions of Service & Consent to Treat

Client: _____ DOB: _____

Clear View Trauma Therapies, LLC.
Springfield, MO 65804
Phone: (417) 770-3309 Fax: (417)

Confidentiality

- I am aware that information about my treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal statutes and regulations or when ordered by a court of competent jurisdiction.
- I understand that billing information relating to the services I receive could be released to certified public accountants or to auditors hired by Clearview Trauma Therapies, LLC to fulfill any and all agreements which are required to verify proper accounting procedures and accuracy.
- I understand that as a condition of my receiving treatment, Clearview Trauma Therapies, LLC may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this center. These uses and disclosures are more fully explained in the Privacy Notice.
- I understand that I have the right to restrict how my health information is used or disclosed. Clearview Trauma Therapies, LLC does not have to agree to my request for the restriction, but if agreed, is bound to abide by the restriction as agreed.

Conditions of Treatment – Requirements

- Mandated Reporters – I understand that Clearview Trauma Therapies, LLC employees are mandated reporters regarding physical and/or sexual abuse.
- No Harm Agreement – I understand that it is my responsibility to call my counselor in the event that I consider harming myself or others.
- Case Closing – I understand that my case will be closed when there are no services delivered for 90 days or more unless I make special arrangements with my clinician for less frequent care. I further understand that I may reopen my case at any time.
- Cancellation/No Show – I understand that when I fail to notify this office that I am unable to keep my appointment for two consecutive visits, I will be subject to possible termination of my services.

Fees for Services

- I understand the fees for services and I understand that payment is required at the time of service. (Except in cases where insurance will be filed and payment is pending.)

- I understand that if I fail to pay for services received, all billing information, including name, address, place of employment, dates of service received, etc. will be given to a professional collection agency to use in their process of collection. I further agree to pay all collection costs and reasonable attorney fees.

Assignment of Insurance Benefits and Release of Medical Information

- I hereby authorize any insurance benefits to be paid directly to Clearview Trauma Therapies, LLC and I recognize my responsibility to pay for all non-covered services including any additional cost incurred in collecting these amounts. I also authorize Clearview Trauma Therapies, LLC to release any information necessary to process any insurance claim for payment purposes.

Release of Liability on Authorized Releases of Information

- I am aware this authorization constitutes a waiver of all claims against Clearview Trauma Therapies, LLC, its agents, servants or employees as a result of their compliance with this authorization, and that neither Clearview Trauma Therapies, LLC nor any of its agents, servants or employees will have any responsibility for the acts of the recipients of this information with respect to said records after they are made available as I have authorized and requested.

Grievance Procedure

- I have reviewed materials explaining the types of services offered, fees, etc. I have also received a statement of my rights and responsibilities as a client of Clearview Trauma Therapies, LLC including proper grievance procedures should I be dissatisfied with any of the policies and procedures of Clearview Trauma Therapies, LLC

Consent for Treatment and Notice of Privacy Practices

- I understand all the preceding statements and will adhere to these policies during my services with Clearview Trauma Therapies, LLC. I am requesting services of Clearview Trauma Therapies, LLC and agree to be contacted by a representative during or after services to ascertain the results of my treatment and my satisfaction with the services I receive through Clear View Trauma Therapies, LLC
- I acknowledge that on _____ I have received the notice of Privacy Practices of, CVT, LLC which describes how my personal health information may be used.

_____ _____

Signature of Client or Legal Guardian Date Witness Date