OVERTURF THERAPY SERVICES INTAKE PAPERWORK & INFORMATION

William Overturf Jr. MSW, LSW

OVERTURF THERAPY SERVICES

William Overturf Jr. MSW,LSW
overturftherapyservices@gmail.com
(380)-203-4165

Dear New Client:

Welcome! I am a Licensed 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. I am currently under the direct supervision of Jennifer Haywood, LISW-S, LICDC-CS.

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, 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 cancel 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.

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

Respectfully,

William M. Overturf Jr MSW,LSW
(he/him/his)
overturftherapyservices@gmail.com
308-203-4165

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

Signature of Client, Parent, or Guardian:

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Signature	Print Name	Date

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1. Introduce Yourself

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

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

Chosen Name or Nickname: _____ Pronouns: _____

Address (Full with 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 William Overturf Jr. MSW, LSW to release/exchange treatment information with my family physician and health plan's utilization reviewers in order to facilitate my treatment by William Overturf Jr. MSW, LSW.

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

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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

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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. I am under the supervision of Jennifer Haywood, LISW-S, LICDC-CS.

Cost of Services: The cost of the sessions are as follows: $100 for an individual session, $150 for the initial assessment session, $150 for ongoing couples therapy, $150 for ongoing family sessions and $50 for reports needed, and $150 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; William Overturf Jr. MSW, LSW 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.

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Missed Appointment and Cancellation Policy: If you know you are going to have to cancel an appointment, contact this therapist at (380) 203-4165 as soon as possible. If I do not answer, leave a message. Please let me know if you desire to reschedule your appointment 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 William Overturf Jr. does not fill out disability, FMLA or other paperwork related to worker's compensation. If you need William to talk to your physician and collaborate on a report that he/she will be filling out please let her know,

**If you are going to need William Overturf Jr. MSW, LSW 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 William Overturf Jr. MSW, LSW, 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 William Overturf Jr. MSW, LSW. I understand that I may terminate clinical services and this consent at any time.

Your signature below indicates your agreement to obtain treatment by William Overturf Jr. MSW, LSW.

Signature of Client, Parent, or Guardian:

_____	_____	_____
Signature	Print Name	Date

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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?

_____
_____
_____

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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?

_____
_____
_____

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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, William Overturf Jr. MSW, LSW, handles medical and clinical information about you, and law regulates how that information is handled. To comply with the law, William Overturf Jr. asks you to receive this notice and sign an authorization form.

William Overturf Jr., 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 William Overturf Jr. to not use and disclose information about you for any other reason than is listed in the authorization. William Overturf Jr. 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: William Overturf Jr. 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: William Overturf Jr. 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/aw: 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 he 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 William Overturf Jr.) 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 he 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 William Overturf Jr. 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 William Overturf Jr., 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 William Overturf Jr., under most circumstances,

Amendment: You have the right to have William Overturf Jr. 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: William Overturf Jr., is required by law to keep medical information about you private and to give you this notice. He 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 January 8, 2021 until revised by William Overturf Jr.

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Payment for Services

Credit card information to be kept securely and privately on file in the event of a no show or late cancel.
You may also elect to use this for your session fee or copay.

Credit Card Holder Name: _____

Credit Card Number: _____

Expiration: _____ Security Code: _____

Please note 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 cancel could also result in a $75 fee as well.

Your signature below indicates your agreement to receive services from William Overturf Jr. MSW, LSW and understand that you are financially responsible for any balance or copay not covered by your insurance.

Signature of Client, Parent, or Guardian:

_____	_____	_____
Signature	Print Name	Date