

Brightside Counseling, PLLC
Abigail Schaber M.Ed., LPCC
Phone: 502.338.9221
73 Cavalier Blvd., Suite #309, Florence, KY 41042
Email: brightsidecounselingnky@gmail.com

CLIENT INFORMATION

Client Information:

Date: _____

Client Name: _____
Last First Middle

Gender: ___ Male ___ Female

Primary Address: _____

City/State: _____ Zip: _____

Phone Home: (____) ____-____ Cell: (____) ____-____

Work: (____) ____-____

OK to leave message at this number? (Y/N) Home: ____ Cell: ____ Work: ____

Email: _____

OK to send email to this address? Y/N: _____

Date of Birth: ____/____/____

Marital Status: Married Single Divorced Separated Widowed

Employment Status: Employed Student Unemployed

Primary Care Physician: _____

Phone: (____) ____-____

May we contact your Primary Care Physician? (Y/N) _____ If so, you will be asked to sign a release of information granting permission.

Emergency Contact Information:

Name: _____

Relationship: _____ Phone: (____) ____-____

Are you seeking counseling related to a court order or legal proceedings? ___Yes ___ No

Who referred you to our practice? _____

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INFORMED CONSENT

This form is to document that I, _____, give voluntary permission and consent to receiving professional clinical counseling services from Abigail N. Schaber, with Brightside Counseling, PLLC.

Purpose and Background:

The purposes, goals and treatment procedures of the professional clinical counseling services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by my therapist. Potential benefits, risks and limitations of professional clinical counseling services have been explained to me as well as alternative procedures or interventions if they exist.

Confidentiality:

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

HIPAA

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy; I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have read and received a copy of the Notice of Privacy Practices (attached).

Attendance:

I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of \$75.00 per missed appointment.

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NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices Effective 12/01/2009

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 12/1/09 **and will remain in effect until we replace it.**

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you with your consent.

Payment: We may use and disclose your health information to obtain payment for services provided to you with your consent.

Healthcare Operations: We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staff performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any other disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may

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disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons involved in your care: We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required By Law: We may use or disclose your health information when we are required to do so by law such as in legal response to valid judicial, administrative subpoenas or court orders.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may provide you with appointment reminders (such as voicemail messages, postcards or letters) unless you make a specific request to the contrary. (See alternative communication section 33).

Patient Rights

Access: You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We would use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first requests for copies. We will charge \$.20 per page and \$25 an hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. In some circumstances, our denial of your request to inspect and receive copies of your information is not subject to review.

Disclosure Accounting: You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include disclosures made for treatment payment or healthcare operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record requests must state the time desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to 12/1/09. **The first disclosure record requests a 12 month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any cost.**

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Restriction: You have the right to request to place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. The request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternate the means or location of the request. We will make reasonable efforts to accommodate your request.

Amendment: You have the right to request that we correct your records if you believe information in your record is incorrect or important information is missing, by submitting a written request that provides the reason for requesting the amendment. We have the right to deny your request to amend the record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion the record is accurate.

Questions and Complaints: If you are concerned that we have violated your privacy rights, disagree with the decision made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the US Dept. of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint

Privacy Officer: Brightside Counseling
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ADULT INTAKE QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

1. Why have you come for therapy (presenting issue for Client)?

2. How long has this been an issue? _____

3. What have you tried to do to resolve this issue?

4. What are your goals for counseling? _____

5. What are your strengths (talents, personality characteristics, things that you like about yourself or think that you are good at)?

6. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency use):

7. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain:

8. Who resides with you in your home?

<u>Name:</u>	<u>Relationship:</u>	<u>Age:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Medical History:

Health (describe your general health as well as any chronic conditions including pain) _____

10. Who is your primary care physician? _____

11. When was your last complete physical exam by an M.D.? _____

12. Are you currently under the care of an M.D. for any condition? Yes___ No___

If yes, please explain: _____

Please list all current medications including over-the-counter and prescription medications:

<u>Name of Medication:</u>	<u>Dosage:</u>	<u>Date Started:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list prior medication for mental health issues, chemical dependency or alcohol use:

<u>Name of Medication:</u>	<u>Dosage:</u>	<u>Date Started:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. Health Concerns

Please check any of the following that apply:

- | | |
|--|--|
| <input type="checkbox"/> Significant weight gain/loss in the last six months | <input type="checkbox"/> Dieting |
| <input type="checkbox"/> Food/drug allergies | <input type="checkbox"/> Overeating or eating too little |
| <input type="checkbox"/> Problems chewing or swallowing | <input type="checkbox"/> Sleep issues |

If any box is checked, please explain: _____

Do you have any functional limitations that affect your daily living (ex: physical impairments, problems with self care, speech, vision, or hearing)? Yes___ No___

If yes, please explain: _____

14. Legal History:

Please place an "N" for none, "C" for currently experiencing, or "P" for experienced in the past.

DUI _____ Bankruptcy _____ Divorce _____
Unemployment _____ Domestic Violence _____ Custody Dispute _____
Disability Claim _____ Workman's Compensation _____

15. Financial Problems or Concerns: _____

16. Educational Background (highest grade completed): _____

17. Employment History (Please describe current job briefly):

18. Have you served in the military? Yes___ No___

If yes, to what capacity? :

19. History of Abuse:

Please place an "N" for none, "C" for currently experiencing, or "P" for experienced in the past.

Verbal Abuse _____ Emotional Abuse _____ Childhood Abuse _____
Physical Abuse _____ Spouse Abuse _____
Sexual Abuse _____ Elder Abuse _____

20. Alcohol and Drug Use:

Do you drink alcohol? Yes___ No___ If yes, how often? _____

When was the last time you had a drink? _____

How much did you drink at that time? _____

Do you have any history of using or abusing drugs/medications? Yes___ No___

Do you currently abuse any drugs/medications? Yes___ No___

What substances have you used in the last 6 months? (check all that apply)

[] Marijuana/ "Pot" [] Cocaine [] Inhalants/ "Huffing"
[] LSD/ "Acid" [] Amphetamines/ "Speed" [] Other
[] Pain Killers [] Sedatives/ "Downers" [] None of Above

If "Other" is checked, please explain:

Check any of the following that has occurred as a result of your drinking or drug use:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arrest | <input type="checkbox"/> DUI | <input type="checkbox"/> Family Problems |
| <input type="checkbox"/> Public Intoxication | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Arguments |
| <input type="checkbox"/> Work Problems | <input type="checkbox"/> Health Problems | <input type="checkbox"/> Relationship Problems |

Do you use Nicotine? Yes No Amount? _____

Do you use Caffeine? Yes No Amount? _____

21. Sexual/Affectionate History:

Are you satisfied with your sex life? Yes____ No____

Do you have any concerns or question about your sexual orientation or experiences? (If so, please explain)

22. Religious/Spiritual History:

Do you have an identified religious preference? _____

23. History of Harm to Self or Others:

Do you currently have any urges/thoughts of hurting yourself? Yes____ No____

Any current urges/thoughts of hurting another? Yes____ No____

Any history of hurting self or suicide attempt? Yes____ No____

Any history of physical aggression toward another Yes____ No____

If yes on any of these questions, please describe:

24. Is there anything else you would like your therapist to know:
