Shaw Living
Behavioral Health Intake
Please bring these forms to your initial appointment.

Please note: All information you provide is protected and confidential information.

Identified Patient Name:

_____

(Last) **(First)** **(Middle Initial)**

_____

(**Last)** **(First)** **(Middle Initial)**
Name of parent/guardian (if under 18 years) ***Minors must be accompanied by a *legal guardian* to all visits**

Birth Date: _____/_____/_____ **Age:** _____ **Gender**: _____

Marital Status: ☐ Never Married ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age:

_____

_____

Address:

_____

_____

City, State **Zip Code**

With whom do you live? (include roommates, spouse, children, relatives, pets etc.)
Name **Age** **Relationship**

_____

_____

_____

Home Phone: (____) _____ ____ May we leave a message? ☐ Yes ☐ No
Cell/Other Phone: (____) _____ May we leave a message? ☐ Yes ☐ No
Email: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of Emergency Contact: _____
Phone: _____

Relationship to You: _____
Referred by: _____

General Health and Mental Health Information

How would you rate your current physical health? (please circle)

Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits? (please circle)

Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise?

_____

What types of exercise do you participate in?

_____

Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?

☐ No

☐ Yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ No

☐ Yes, When did you begin experiencing this? _____

Are you currently experiencing any chronic pain? NO ☐

☐ Yes, Please describe. _____

_____

Do you drink alcohol more than once a week?

☐ No ☐ Yes, How often? _____

Do you engage in recreational drug use?

☐ No ☐ Yes, How often? _____

Are you currently in a romantic relationship? ☐ **No** ☐ **Yes If yes, for how long?**

_____

On a scale of 1-10, how would you rate you relationship_____

*1=Poor 10=Excellent

What significant life changes or stressful events have you experience recently?

_____

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication? ☐ No ☐ Yes, please list medications and current prescriber:_____

Have you ever been prescribed psychiatric medication? ☐ No ☐ Yes, please list and provide dates:

_____

_____

What do you do to relax? _____

_____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, etc.)

Alcohol/Substance Abuse	☐ Yes	No ☐	_____
Anxiety	☐ Yes	No ☐	_____
Depression	☐ Yes	No ☐	_____
Domestic Violence	☐ Yes	No ☐	_____
Eating Disorders/Obesity	☐ Yes	No ☐	_____
Post-Partum Mood D/O	☐ Yes	No ☐	_____
Obsessive Compulsive Behavior	☐ Yes	No ☐	_____
Schizophrenia	☐ Yes	No ☐	_____
Suicide Attempts	☐ Yes	No ☐	_____
Completed Suicide	☐ Yes	No ☐	_____

Additional Information:

What is your occupation?

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

Do you consider yourself to be spiritual or religious?

☐ No

☐ Yes, please describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

Are you here for an evaluation only? _____If so, who referred you?

_____

If you are here for therapy, what you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____

Any other information you would like for us to know about you: _____

_____

_____

_____

_____

_____

Patient Rights and HIPPA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPPA").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address:

   2484 E Pinetree Blvd, Thomasville, GA 31792

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPPA.
5. If this office initiated this authorization, you **must** receive a copy of the signed authorization.
6. SPECIAL INSTRUCTION FOR COMPLETING THIS AUTHORIZATION FOR THE USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES.
   HIPPA provides special protection to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPPA as notes recorded by a health care provider who is a mental health, professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

   <u>In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign a specific separate authorization to allow for the release of Psychotherapy Notes</u>.

   By signing I acknowledge that I have read and understand the above information.

_____ _____

Printed Name Signature

_____

Date

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or plans to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggest that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to controlled substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client's Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

Please ensure that our office has all updated and correct phone numbers to reach you.

A full fee is charged for missed appointments or no-show cancellations with less than 24-hour notice unless due to an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment.

Thank you for your consideration regarding this important matter.

Client's Signature (Client's Parent/Guardian if under 18) **Date**

NOTICE OF PRIVACY PRACTICES FOR MENTAL HEALTH

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISLCOSED. PLEASE REVIEW IT CAREFULLY
(Required by the Health Insurance Portability and Accountability Act-45CFR Parts 160& 164)

TREATMENT: Our staff members may disclose your health information to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory test results and treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted to treat you.

Payment: Your health information may be used to seek payment from your insurance plan. For example, your health plan may request and receive information on dates of services, the service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Shaw Center. For example, we may call you by name from the waiting room.

Law Enforcement: Your health information may be disclosed to Law Enforcement agencies, without your permission, to support government audits and inspections, and to comply with government mandated reporting. Also, when a client discloses intentions or plans to harm another person, mental health professionals are required to warn the intended victim and report this information to legal authorities. If a client states or suggest that he or she is abusing, or has abused a child, or vulnerable adult, the mental health professional is required to report this information to the appropriate social service and /or legal authorities.

Public Health Reporting: We may disclose your health information to public health agencies as required by law.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation or the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Shaw Center Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practices. We are also required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, Shaw reserves the right to amend or modify our privacy policies and practices as required by changes in Federal or State laws and regulations.

Patient Rights:

- To obtain a paper copy of this notice
- Inspect and copy of your health record
- Obtain an accounting of disclosures of your health information
- Request a restriction on certain uses and disclosures of your information

☐ I agree to the above limits of confidentiality and understand their meanings and ramifications. I have also read and/or received a copy of this privacy notice.

_____ _____

Patient Signature/ Legal Guardian/Parent Date

☐ I do not agree with the above limits, but understand they may be disclosed for the above reasons. I have also read and/or received a copy of the privacy notice

_____ _____

Patient Signature/ Legal Guardian/Parent Date

This authorization covers the period of health care from _____ to _____

I authorize the following individuals to have access to my Mental Health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer by protected by federal or state law.

Name	Relation

Behavioral Health Financial Agreement

Shaw Center for Women's Health/Shaw Living

FEE INFORMATION: A therapy session normally lasts 30-60 minutes. A follow up normally lasts 30-60 minutes. You will be billed for the total time spent on the patient's behalf. Our basic fee schedule is as follows:

For clinical treatment the billing rate is not to exceed:

Initial Evaluation:	45-60 minutes	$340.00
Individual Session:	15-30 minutes	$145-$210
Individual Session	45-60 minutes	$180-$325

Legal work will be done at the clinician's discretion and a rate negotiated in advance, usually $150 to $350 per hour and may be billed separately from Shaw Center for Women's Health. Expert witness and court testimony by the clinician will be billed at a different rate.

Phone Calls are subject to billing at the above rates at the clinician's discretion. These are generally not reimbursable by third party payers (insurance companies) and are the responsibility of the patient.

Appointments not canceled within 24 hours will be rescheduled and charged a fee of $50. No show appointments (unless due to an emergency) will be charged a fee of $100.

These are the most common billing situation. Actual bills may vary depending upon unusual circumstances, extra time, variability associated with deductibles, copays and managed care limits.

INSURANCE/BILLING INFORMATION: It is your responsibility to contact your insurance carrier to determine if your insurance will cover outpatient mental health services and to what limits this coverage extends. Insurance claim forms are completed by our office as a courtesy to you. We do not accept responsibility for collecting your claim or negotiating a settlement on a disputed claim. Assuming your insurance will "take care of the bill" is not wise. Payments by insurance companies vary widely and sometimes are guided by "usually, customary and reasonable fees." Their payments do not always meet what our clinicians charge and you are responsible for any unpaid balance. If your insurance company requires a referral, it is your responsibility to keep your referrals current for each patient being billed. Please be advised insurance companies, Medicare and Medicaid in particular do not find phone calls a covered benefit. If clients do not show up or call to cancel, the clinician may call you to check on your status. The cost for this call would be your personal responsibility as no insurance company will pay for this service. To avoid this please agree to be present at your scheduled appointment or provide us with at least 24-hour notice of a cancellation.

____ Shaw Center/Shaw Living requires 24-hour notice to cancel appointments without you being charged a fee. Emergencies are exempted (it is the clinician's discretion as to what is deemed an emergency). Insurance companies do not pay for No Show or late cancelled appointments. By my initialing this, I acknowledge I understand the cancellation policy.

For those without insurance, our policy is to collect payment in full at the time of service. However, some exceptions may be made if negotiated with billing department personnel prior to your appointment (i.e. payment plans).

Keep monthly statements and when you receive an explanation of benefits from your insurance company, compare it to your monthly statement to see what they paid for a given charge. Any payments you have made to Shaw Center for Women's Health/Shaw Living which your insurance later pays will be refunded to you. If you are unwilling to assign insurance benefits directly to Shaw Center for Women's Health/Shaw Living and choose to file your own claims and receive payment directly from your insurance carrier, you will be expected to assume total responsibility for your account and pay in full at the time of your visit.

I hereby agree to be directly responsible for all charges incurred at Shaw Center for Women's Health/Shaw Living and acknowledge that I fully understand the above and will comply with these guidelines.

_____

Patient or Responsible Party (Signature required by any client age 14 or older) Date Witness

I hereby authorize Shaw Center for Women's Health/Shaw Living to disclose to my insurance company mental health records which may include diagnosis, prognosis and summary of care information in the processing of my insurance claim. This DOES NOT include therapy progress notes, testing and/or evaluation reports. If your insurance company requests additional information, you will be notified about the request and given a specific Release of Information form that would allow Shaw Center for Women's Health/Shaw Living to release these records. Upon your signature below, you agree that insurance payments will be paid directly to Shaw Center for Women's Health/Shaw Living for charges incurred. Photostatic copies of this authorization shall be accepted as valid as the original and also may be used for insurance claims.

_____

Patient or Responsible Party (Signature required by any client 14 or older) Date Witness