Connections Wellbeing Center (Guard Their Hearts) – Intake Form

Aviva Kohl, LCSW/R 845-269-5008

Who referred you to our office: _____

Name: _____ Preferred name: _____

Gender: M / F Maiden name: _____ Age: _____ Birthdate: _____
Address: _____

City, State, Zip: _____

Who is Financially Responsible for Payment: _____

Home Phone: _____ Cell: _____ Can I leave a message? _____

Best # to call_____ Between what hours: ____AM _____ PM

Email: _____

Place of Employment & phone #: _____

Please list all family members (spouse, children, and include others living in your home) and any other important people in your life:

If you are currently involved or expect to be involved in any legal proceedings, you MUST inform us at or before our first meeting. We reserve the right to refuse to testify or offer a professional opinion in such proceedings, although we may also choose to do so at your request.

Emergency Contact: _____ Phone: _____

Relationship: _____ Address: _____

Alternate Phone: _____

Allergies and Health Concerns:
_____

Why are you seeking therapy at this time?

How long has this been a problem and what have you tried in the past (please list therapists and their credentials and specialties, and any treatment modalities used)?

What are your goals for therapy?

Are you currently or have you ever seen a psychiatrist (please include their name)? Please list any current medications.

Do you have any past psychiatric history including hospitalizations? Please describe below.

NOTICE OF PRIVACY PRACTICES - Terms of Care

Welcome to Connections Wellbeing Center. Please read the following document carefully, as it contains important information regarding the treatment you and/or your family will receive in this office, and how medical information about you may be used and disclosed. After careful review, please sign your acknowledgment of our policies and procedures.

Privacy Practices & Patient Rights: We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. I am required to follow the terms of the Notice of Privacy Practices currently in effect. The information you share with us is held in the strictest confidence and may not be released to anyone without your written consent, as prescribed by law. A HIPPA release form will be provided for each person or practice with whom you would like us to be able to have contact, including specific requests for limitations on the sharing of information. There are a few exceptions to this which are also regulated by State law:

Duty to Warn and Protect: When a client discloses intentions or a plan 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 healthcare 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 suggests 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 (under age 14) have the right to access the clients' records.

Insurance Providers or other sources of payments: Insurance companies are given information that they request regarding services to clients, and this may be extended to third-party non-profit organizations that cover your bill, or credit card companies that you may use to pay for services. This may include types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, and intake/discharge summaries, but does not apply to regular session notes.

Professional Supervision: As the supervisor of Connections Wellbeing Center, Aviva Kohl will be consulted with, and oversee all clients seen in the office. We may consult with other healthcare professionals for purposes of evaluation, diagnosing, and providing treatment.

Law Enforcement/Litigation: We may disclose your health information to law enforcement agencies as required by law or in response to a court order or subpoena.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support financial reporting and activities to evaluate and promote quality.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, physician's offices are required to report certain communicable (contagious) diseases to the state's public health department.

Worker's Compensation: I may release your information to Worker's Compensation agencies in the event that your illness or injury may be related to work.

Military/Veterans: If you are a member of the armed forces or a veteran, I may release your information as required by military command authorities.

These above situations are the only exceptions to otherwise 100% confidentiality of what you talk about during therapy unless you have given us your specific written permission. If you change your mind after giving a use or disclosure of your information, you may submit a written revocation of your authorization, (remove permission to share your information). However, the decision to remove permission will not affect or undo any sharing of information that occurred before you notified this office of the change of decision. Information subpoenaed by a valid court order is usually not protected by this limit on confidentiality.

Upon signing consent to release information, you are encouraged to discuss the amount, type, and purpose of information to be released if you have any concerns in the area. Our policy is to allow you to maintain the highest possible level of confidentiality.

Requesting Restrictions: You may ask us to limit our use of disclosure of your protected health information. We are not required to agree to your request, but if we do agree to it we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit my use or sharing, and 4) state to whom the restriction applies. You may revoke (discontinue) your restriction at any time by contacting the office.

Confidential Communications: You may ask that we communicate with you in a particular way, or at a certain location, to keep your privacy/confidentiality. Your request must be in writing, telling us how you will maintain your financial responsibility, and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request. You may revoke your request at any time by contacting us. Please note that email is not a guaranteed form of communication. Any email communication sent to our office should have "confidential" in the subject heading, but we are unable to guarantee complete confidentiality of email communication.

Inspect and Copy: You may request access to inspect and receive a copy of your assessment, diagnosis, and treatment plan from this office unless the law restricts it or it is against my professional judgment to share it with you. The request must be in writing. I will act on your request for copies within 30 days after I get it. There is a fee for the copies of your records and the postage incurred.

Amendment: You may ask us to amend your health information if you believe that it is incorrect or incomplete.

Accounting: You have the right to obtain an accounting of how and to whom your protected health information has been disclosed.

Printed Copy: You are entitled to receive a paper copy of our Notice of Privacy Practices.

Filing a Complaint: If you believe that we have violated your privacy rights, you should call the matter to my attention. This is your right and it is important that you feel safe and comfortable to discuss these concerns.

Right of Reversae of Privacy Practices

As permitted by law, we reserve the right to amend or modify these privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the

reason for these revisions, I will provide you with a revised notice on the next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Fees and Billing: Each client (parent/legal guardian for minors) is responsible for payment of services rendered on the day of the appointment. Cash or check is accepted.

- Session Fee: To be discussed, based on insurance options
- No-show fee: Regular session fee (without 24 hr. cancellation)
- Other services: court preparation, school consultations, court appearances: Session rate per hour.

Since we reserve your appointment time, there will be a charge for any appointments missed **without 36-hour advance notice. To avoid this charge, it is essential for you to cancel your appointment at least 36 hours in advance in the case you will need to miss the session.**

Phone calls and other contact: Sessions are usually scheduled at the end of the preceding session. If you need to reschedule your appointment, please leave a message on your therapist's voicemail or text, and you can expect a return contact within 24 hrs. If you do not receive a call back within 24 hrs., feel free to call again. **Cancelling sessions can be done in the same manner 36 hrs. in advance to avoid the no-show fee**. Please include your name, the appointment time, and a contact phone number.

We understand that there may be times when you need to speak with us outside of your scheduled appointment. If a need for this does arise, please feel free to leave a message on your therapist's number. We will make every effort to call within 24 hrs. Please reserve these messages for times when the matter is urgent, as we devote most of our time to direct client care.

In the event of an emergency, it is recommended that you call Mobile Mental Health, 911, or your local medical doctor, whichever is most appropriate for the situation. We can assist you with referrals for psychiatric consultation if needed.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, RIGHTS AND FEES

By signing below, I acknowledge receiving a summary of the privacy practices, patient rights, and fee schedule of Aviva Kohl, LCSW-R.

Client's name:_____ Client's date of birth:_____

Signature: _____ Date: _____

Please initial each item below:

_____ I agree to pay the fee of $_____cash/check per session at time of services.

_____ I agree to the Terms and Conditions as agreed upon at the time of service.

_____ I agree to pay $_____ if I fail to keep an appointment without notifying my therapist with 24 hours notice.

_____ I understand that I will not be able to schedule a future appointment without paying any unpaid balance unless alternative payment plans have been made with the therapist.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____