

Child and Community Counseling LLC
Dr. Alisa Faust-Halle
9135 North Meridian Street, Suite A-6
Indianapolis, Indiana 46260

Please print and answer all questions. Thank you.

Child's Name _____

Address _____

City, State, Zip code _____

Preferred Phone _____

Alternate Phone _____

Birth date _____ Age _____ Grade _____ School _____

Mother's name _____ Father's name _____

Address of either parent if different from child _____

Family doctor _____ General Medical Condition _____

Current Medications (names and dosage) _____

Referral Source _____

Previous Counseling _____

Presenting Problems _____

Marital Status of Mother _____ Father _____

Emergency contact _____

Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

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

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

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

Date

Child and Community Counseling LLC
9135 North Meridian Street, Suite A-6
Indianapolis, Indiana 46260
(317) 581-1433
www.indianapolis-therapy.com
childandcommc@gmail.com

Insurance Verification and Eligibility

Patient Name _____

Patient Date of Birth _____

First Appointment Date _____

Address _____

Preferred Phone Number _____

Insurance Name _____

Insured Date of Birth _____

Insured SSN _____

Insured Employer _____

Insurance Name _____ Ins.Phone _____ Ins. Fax _____

ID/Claim # _____ Group # _____ Effective Date _____

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered. **Initial** _____

I understand/agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting this bill. **Initial** _____

I understand/agree that if I do not attend a scheduled appointment and fail to provide 24 hours of notice in advance (except if ill) I will be charged a No Show fee. I also understand that I can be charged additional fees for phone consultations beyond 15 minutes, meetings, letter writing, and completing forms longer than one page. **Initial** _____

Required HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

i. For Treatment. I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my colleagues for peer supervision. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case.

ii. To Obtain Payment for Treatment. I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

iii. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

iv. For Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

i. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.

ii. When judicial or administrative proceedings require disclosure. For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.

- iii. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
- iv. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
- v. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
- vi. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
- vii. For specialized government functions. For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.
- viii. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object. Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you

can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- A. **The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.

- B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

- C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

Therapy Changes

D. **The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. **HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the

