ADVANCE PROFESSIONAL COUNSELING INTAKE

Name, First: ________________________ Middle: ______________ Last: ___________________

Date of Birth: _______ / _________ / ______

Social Security Number: ________ - _______ - ___________

Referral Source: ____

Name of PCP: ____

Marital Status: __________________________________

Address, City, State, Zip:

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Mobile Phone: ____________________ Home Phone: ___________________ Work Phone: _______________

Email Address: ____

History of present problem: symptoms, onset, duration, frequency, etc.:

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Past psychiatric history: prior treatment, symptoms, diagnoses, hospitalization, suicide attempts, or violent history:

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Trauma history: the nature of the trauma, current trauma, persons involved, etc.

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Family psychiatric history: history of mental illness in the family, diagnoses, etc.

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Medical conditions & history: current and past medical conditions, treatments, allergies, etc.

Substance Use: substance, start date, last used, amount, frequency, etc.

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Family History: family of origin, relationship with parents, siblings, significant others:

Medical History: significant relationships, social support, nature/quality of relationship, etc.:

Developmental History: developmental milestones, delays, etc:

Educat

ional/Occupational History: level of education, current/past employment, etc.:

Legal History: arrest history, DUI occurrences, etc.:

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Strengths/Limitations:

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Otherinformation:

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Please list any prescription medications you currently take, include name, dosage, and frequency:

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Please list any over-the-counter medications you currently take such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc., include name, dosage, and frequency:

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Advance Professional Counseling, LLC to:
1) Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.
2) Bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care.

I acknowledge:
1) I am responsible for all charges not covered by my insurance, including missed appointments.
2) Any money credited as overpayment due to me will be refunded after completion of treatment.
3) I will be charged for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time.

Client's Signature & Date:
____ Date: ______ / ____ / 20_____

Responsible Party Signature & Date:
____ Date: ______ / ____/ 20_____

Authorization to Release Protected Health Information

I, ____, hereby authorize Name of Client/Guardian ______William R. Coburn____ of Advance Professional Counseling, 1025 Main Street, Wheeling, WV (304) 650-3820, to disclose or receive, a copy of specific health/mental health information initialed below regarding _______________________________ consisting of:

__Therapy/case notes __Psychological reports __Progress reviews
__ Psychiatric reports __Medical reports __ Treatment Plans
__Medications used in treatment __ Assessments __School reports
__ Discharge Summary __ Psycho-educational reports
__ Results of court proceedings (other than expunged records)
__Other (specify): ____

to or from (name and address of recipient or Sender):___

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Name, Title, Business Name, Address, and Phone Number

I have been informed and fully understand that this protected health information may be in written, oral, or report form. I understand that the information used or disclosed related to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/ AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information. I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits. You may revoke this authorization in writing anytime, but such recovation may not be retroactive. If you revoke your authorization, the information described above may no longer be disclosed for the purposes described above. To revoke this authorization, please send a written statement that you are revoking this authorization to Advance Professional Counseling at the address listed above. I have read this authorization and I understand it. Unless revoked, this authorization expires in 180 days from the date of the signature below.

Signature: ____Date:________________

Individual, Legal guardian, or Personal representative

Description of personal representative's authority: _____________________________________

Advance Professional Counseling, LLC
Mull Center 1025 Main St. Suite 317
Wheeling, WV 26003 (304) 650-3820

HIPAA Privacy Notice

Notice of Privacy Practices
Effective Date: November 2013
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.
What is this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to ead. This notice tells you how the practitioners at Advance Professional Counseling required to be HIPAA compliant will protect your medical information, how I may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact me directly at (304) 650-3820.
Understanding Your Health Information during each appointment, I record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance Company) can verify that services you received were appropriately billed
- A tool with which I can assess and work to improve the care I provide Your Health Information Rights You have the following rights related to your medical record:
- Obtain a copy of this notice.

You can read this notice in the waiting room, and you can also obtain your own copy if you would like.

- Authorization to use your health information.

Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

- Access to your health information. You may request a copy of your medical record from me at any time.
- Change your health information. If you believe the information in your record is inaccurate or incomplete, you may request that I correct or add information.
- Request confidential communications. You may request that when I communicate with you about your health information, I do so in a specific way (e.g. at a certain mail address or phone number). I will make every reasonable effort to agree to your request.
- Accounting of disclosures. You may request a list of disclosures of your health information that I have made for reasons other than treatment, payment or healthcare operations.

My Responsibilities

- I am required by law to protect the privacy of your health information, to provide this notice about my privacy practices, and to abide by the terms of this notice. Advance Professional Counseling, LLC Mull Center 1025 Main St. Suite 317 Wheeling, WV 26003 (304) 650-3820

- I reserve the right to change my policies and procedures for protecting health information. When I make a significant change in how I use or disclose your health information, I will also change this notice.
- Except for the purposes related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, I will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

When Can I Legally Disclose Your Health Information Without Your Specific Consent?

- In order to facilitate your medical treatment.

For example: Your primary care physician or your psychotherapist might call me to discuss your treatment, and in that situation I would disclose information about your diagnosis, your medications, and so on.

- In order to collect payment for health care services that I provide.

For example: In order to get paid for my services, I have my billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, I fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.

- In order to facilitate routine office operations.

For example: Occasionally, I dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

Will I Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), my office policy is that I will never share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, I will do whatever is necessary, even if that means breaching confidentiality. Less Common Situations in Which I Might Disclose Your Health Information

- Workers compensation: I may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
- Law enforcement: I may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
- Food and Drug Administration (FDA): I may disclose to the FDA your health information relating to adverse events due to medications.
- Business associates: I hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us any time at (304) 650-3820. If you feel your privacy rights have been violated in any way, please let me know and I will take appropriate action. You may also send a written complaint to: Department of Health & Human Services, Office of Civil Rights, Hubert H. Humphrey Building 200 Independence Avenue S.W. Room 509 HHH Building Washington, D.C. 20201Advance Professional Counseling, LLC

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Name: ____

Date: _____/____/ 20_____

Signature:

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Witness:

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