CLIENT INFORMATION

Date of initial contact_____1st Appointment _____ 2nd Appointment_____

Today's Date_____

Name _____ Age __Date of Birth ___/___/___ SS # _____

Race/Ethnicity _____ Gender_____

Address _____ City _____ State _____ Zip _____

Mailing Address:

_____

(If different from above)

_____

Phone (H) _____Can you receive messages? Yes ___ or No___

Phone (W) _____ Can you receive messages? Yes ___ or No___

Phone (C) _____Can you receive messages? Yes ___ or No___

List e-mail Address where you can receive messages_____

Can you receive messages by: Text? Yes ____ No ____

Marital Status: Single ____ Married ____

Employer _____ Position_____

Who referred you to O'Neill Counseling Services?

In Case of an Emergency Call: _____

Phone#: _____

Relationship _____

NAME OF GUARDIAN (FOR CLIENTS UNDER THE AGE OF 18)

Name: _____Relationship to Client: _____

Phone #: _____ Address _____

Medical Information

Client's Name _____ Date _____

Prescribing Physician: _____

Primary Care Physician _____

Last Medical Exam_____ Reason _____

Previous Mental Health Provider_____
(Contact Info & duration)

_____

Psychiatrist_____
(Who, what, where, when, duration)

_____

Medical History:

Current Medications:

Medication(s)	Start Date	Current Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____

Your Peace of Mind
Therapeutic Services, LLC
Everyday is a new day to be the better part of you

INSURANCE INFORMATION

Insurance Information - Primary

Relationship to Insured: Self ____ Spouse ____ Child _____ Other _____

Full Time Student: Yes _____ No _____Occupation_____

Policy Holder Name _____ Date of Birth ____/_____/___

SS #_____ Address _____City _____ State ___ Zip _____

If different from above
Insurance Company _____
Member/Subscriber ID_____ Group #_____

Phone Number for Mental Health Services (*on back of card*)
_____

Insured's Employer _____ City _____ State _____ Zip _____

If different from above
Insurance Information - Secondary
Policy Holder Name _____ Date of Birth ____/___/____SS # _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Member/Subscriber ID_____

Phone Number for Mental Health Services (*on back of card*)
_____

Insured's Employer _____ City _____ State _____ Zip _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I am also responsible for payment of non-covered services.

Signature _____ Date _____

_____
Signature or Parent, Guardian or Personal Representative Date

Office Policies

Psychotherapy Services- During your first visit an assessment will be conducted and you will be asked to read & complete the following forms: Client Information, Medical Information, Insurance Information, office policies, the Notice of Privacy Practices, Consent to Treat, and Release of Information. Note these forms use the terms Licensed Clinical Social Worker (LCSW) and therapist interchangeably.

In general, the number of visits that you will require will depend on the type of problem(s) that exist, the recommendations made by your therapist, and the effort you put into working on the identified problem(s). It is important that you understand that there is no guarantee that psychotherapy will yield positive or the intended treatment outcomes. If you have any questions or concerns about our work, please discuss them with your therapist. You may also seek a second opinion or withdraw from treatment at any time.

Appointments & Cancellations- Therapy sessions are 45- 55 minutes in length on the agreed time, although the initial assessment may be longer. Barring rare emergencies, you will be seen at the scheduled time. Please notify the therapist if you will be more than 10 minutes late. Please note if you arrive late the session will still end 45- 55 minutes after it was scheduled to end and you will be charged the full amount. **Cancellations must be made 24 hours before the time of the appointment.** For example, if you have an 11:00 am Monday appointment, you need to call before 11:00 on the preceding Friday. Emergencies & weather concerns will be taken into consideration.

Private Insurance & Self Pay – A missed session and/or failure to give 24-hours cancellation notice or will result in a fee of $50. The fee is waived if there is availability to reschedule you within the same week.

Husky – Missed sessions and/or failure to give 24-hours cancellation notice more than three times will result in the closing of the case. Termination is waived if there is availability to reschedule your appointment within the same week.

EAP- A missed session and or failure to give 24-hours cancellation notice will result in the closing of the case. Termination is waived if there is availability to reschedule your appointment within the same week.

*** For your safety and the safety of others clients who are under the influence of any substances will not be seen and are encouraged to call and reschedule their appointments to avoid a missed session fee. Your Peace of Mind Therapeutic Services, LLC is a drug and alcohol free safe place and those who visit are asked to respect the therapist and those around them by not bringing or carrying on their person any drugs or alcohol.**

Costs for Services -The fee for an initial Assessment/Evaluation is $175.00. Your therapy session fee is $150..00 for 50 minutes. Insurance companies will only pay for medically necessary direct clinical services rendered during an assessment, group or individual therapy session. With the exception of brief telephone conversations (ten minutes), telephone consultations, report writing, court appearances, supervised visitations, or other professional services are not considered part of your session and are not covered by insurance. These additional professional services are your responsibility and the cost is $100.00 an hour. Copays and self-pay fees are required at the start of each session. A fee of of $25.00 will be applied to returned checks. These fees are subject to change.

Anthem Blue Cross and Blue Shield, Cigna and Husky Insurance are accepted.

* If you are using your insurance to pay for services you are responsible for notifying Your Peace if Mind Therapeutic Services/ Jessica Lazu of any changes to your insurance coverage and for paying any denied claims due to lack of change notification. Additionally, ***you are responsible for paying the entire***

fee of any services not covered by your insurance. Your insurance company will be called prior to your visit to verify coverage. You should be aware that if you are using your health insurance to pay for psychotherapy, your insurance company will require the provider, Jessica Lazu, to inform them of the services provided to you, including clinical information from your files. This information will become part of the insurance company files. If you would prefer not to use your insurance company, please ask about self pay options.

Communication -Voicemail is checked frequently and phone calls will be returned within 24 hours except on weekends and holidays. Text messages are also received, but text messaging is limited to scheduling only. You will receive appointment reminders to the approved email listed in the Client Information form.

Your Peace of Mind Therapeutic Services does not have a 24-hour crisis response line therefore if you are unable to reach the therapist and feel that you can't wait for a returned call, contact your family physician, proceed to the nearest emergency room, or call 911 and describe your circumstances.

Collaboration with other medical and mental health professionals - It is important that your therapist is informed of any medical or mental health treatment you are receiving or have received. Only with your written authorization will information about your past or present mental health or medical treatment will be requested or shared with providers.

Gifts & Invitations - Although the counseling relationship is quite intimate, gifts and invitations are discouraged. Gratitude or appreciation for services rendered can be expressed in session or in a written note.

Records Retention - Records are destroyed 7 years after the last session or 3 years following the death of a client.

Termination of Treatment - Ideally, termination of treatment will be discussed in the beginning or when you are feeling better and have achieved your treatment goals. Typically, you will have less frequent appointment and have a final session.

Resumption of Treatment - Sometimes an issue or life event will prompt you to return for treatment. The therapist will always try to make room for returning clients.

Non-voluntarily Discharge from Treatment - A client services may be terminated if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the practice, and/or (B) the client refuses to comply with office policies, refuses to comply with treatment recommendations, and/or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge in writing. The client may reapply for services at a later date.

I have received and reviewed the Client information form. I understand the requirements and rules of this office, and I agree to the terms therein.

Signature: _____ Date: _____

Therapist: _____ Date: _____

PROFESSIONAL RECORDS:

By law all LCSWs are required to keep a medical record for all clients. The medical record may include, but is not limited to, treatment plans, information sufficient to justify any diagnosis and treatment rendered, dates of treatment, referrals to other services, and actions taken by non-licensed persons when ordered or authorized by the provider.

Collection of Information. Your Peace of Mind Services collects data through a variety of ways such as: assessments, evaluations, letters, phone calls, emails, and voicemails.

Information covered under confidential. All oral and written communications and records thereof relating to the evaluation and treatment of the client(s) are kept confidential. This applies to communications between the client and the social worker, between a member of the client's family and the social worker, and between the client or member of the client's family and an individual participating under the supervision of a licensed clinical social worker in the accomplishment of the objectives of evaluation or treatment. The confidentiality applies wherever the communications took place. This also includes, but in not limited to emails and phone calls (including information left on voice mails), directly or indirectly given to Your Peace of Mind Therapeutic Services/Jessica Lazu.

HOW Your Peace of Mind Therapeutic Services, LLC MAY USE AND DISCLOSE PHI:

Treatment. Your information is only used and disclosed as is reasonably necessary to provide you with mental health therapy services. Your Peace of Mind Therapeutic Services/may use and disclose your PHI to those who are involve in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation/supervision with a LCSW or other treatment team/group members. We may use and disclose PHI to any other consultant only with your authorization.

Payment. Your PHI may be used and disclosed to your health insurance to pay for psychotherapy, your insurance company will require information including clinical information from client files. In addition your PHI may be, if it becomes necessary, used in collection processes due to lack of payment for services rendered (minimum information is used and disclosed). Please note: If a client has paid for services out-of-pocket Your Peace of Mind Therapeutic Services/ will accommodate the clients request not to disclose PHI related solely to those services paid for out-of-pocket if the disclosure is to be made to a health plan for payment or health care operations.

For Health Care Operations. Your Peace of Mind Therapeutic Services/will use and disclose PHI as needed to support our practice activities including but not limited to, quality assessment activities, therapist review activities, and conducting or arranging for other business activities. For example, we may disclose PHI with a third party that performs business activities (e.g. billing or tying services) provided there is a written contract with that business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Uses and disclosure of PHI for marketing purposes. Your Peace of Mind Therapeutic Services/Jessica Lazu and team respects the privacy of clients and will not disclose PHI for marketing purposes including subsidized treatment communications without written authorization from clients.

Research. PHI may only be used and disclosed after a special approval process and/or with your authorization.

With authorization. Uses and disclosure not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that a use or disclosure has already taken place based upon your authorization.

Required by law. Under the law, Your Peace of Mind Therapeutic Services/may disclose your PHI to you upon your request. In addition, your PHI may be disclosed to the Department of Public Health for the purposes of investigating or determining our compliance with the requirements of the Privacy Rule.

Limited Right to Use Non-Identifying Personal Information. Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to Your Peace of Mind Therapeutic Services/ become property of the practice. Jessica Lazu reserves the right to use non-identifying information about clients for educational, fundraising, and promotional purposes without compensation to clients. Clients may specifically request in writing that NO non-identifying information be used for the purpose of education, fundraising, or promotional services. I respect your right to privacy and assure you that no identifying information or photos will be publicly used without your direct or indirect consent.

What is not done with your PHI. Your Peace of Mind Therapeutic Services/Jessica Lazu does not give out, exchange, barter, rent, sell, lend, or disseminate any information about clients that is considered confidential, is restricted by law, or has been specifically restricted by the client in a signed HIPAA consent form.

YOUR RIGHTS REGARDING YOUR PHI/RECORD

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. As a Client, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances where disclosure could or would physically endanger you and/or others; or makes reference to another person and your therapist believes that access is reasonably likely to cause substantial harm to that other person; or where information has been supplied confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. It is recommended that you review the contents with your therapist.

To exercise any of these rights you must submit your request in writing to Annette O'Neill.

COMPLAINTS.

If you have any concerns or complaints please contact Annette O'Neill at (860) 550-1539 or at oneillcounselingservices@gmail.com

The effective date of this Notices is July 2022

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____ DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPPA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jessica Lazu, 860-663-8131.

_____
Signature of Client/Client ***Effective Date***

_____
Signature or Parent, Guardian or Personal Representative ***Effective Date***

_____
- If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____
Signature of Therapist ***Effective Date***

Your Peace of Mind
Therapeutic Services, LLC
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CONSENT TO RECEIVE TREATMENT

Consent to Treatment Agreement
This document (the Agreement) contains important information about our professional services and business policies.

I acknowledge that I have received, have read, (or have had read to me) and understand the Client Information Sheet and/and other information about the therapy that I am considering. I have had all of my questions answered fully.

I do hereby seek and consent to take part in treatment provided at Your Peace of Mind Therapeutic Services. I understand that developing a treatment plan with this therapist and regularly reviewing our work towards meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing that I will still be responsible for is paying for the services that I have already received. I understand that I may lose other services or may have to deal with other consequences if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment that I received. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE WITH ALL OF THESE STATEMENTS.

_____

Client Signature Date

_____

Parent/Legal Guardian Relationship To Client Date

I, the therapist, have discussed the issues above with the client and/or guardian. My observation of this person's behavior(s) and responses give me no reason to believe that this person is not fully competent to give an informed and willing consent to receive treatment.

_____ _____

Therapist's Signature Date

Your Peace of Mind
Therapeutic Services, LLC
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Authorization to Release/Obtain Information

I _____ authorize Your Peace of Mind Therapeutic Services/ to disclose and obtain

information from _____

The purpose of this disclosure is to assist with treatment and coordination of services.

PLEASE INITIAL THE INFORMATION TO BE RELEASED:

_____Initial Evaluation _____Treatment Plan _____Psychological Evaluation

_____Discharge Summary _____Verbal Contact _____Psychiatric Evaluation

_____Educational Records _____ Medical Records _____ Progress Notes

_____ Other _____

I understand that all client information is confidential and cannot be disclosed without my written consent unless otherwise provided for in state and federal law. I understand that I may withdraw this consent at any time prior to the release of the information above. This consent, if not withdrawn *will expire one year from the date signed below on the following day*_____.
I understand that the information to be released/obtained may contain information pertaining to psychiatric, drug and/or alcohol abuse, diagnosis/treatment and confidential HIV/AIDS information.

_____ _____
Signature of Client (18 years old or older) Date

_____ _____
Signature of Parent/Guardian. Date

_____ _____
Signature of Witness. Date