NEW CLIENT INFORMATION

Therapist ______________________________________ **Today's Date:** ___________________________

Client Legal Name: ____ DOB:____________________________

Preferred Name/ Nickname: ____

Gender Identity (Please circle all that apply): M F Transgender Other: ____________________

Address: ____

City: ____ St: _____________ Zip: _______________________

Marital Status: __________________________

Employment Status (please circle one):

Currently Employed Not Currently Employed Looking for Employment

If Employed, where? ____

Is client a dependent child? (Circle) Y N

Parent(s)/guardian(s) name: ______________________________________

Primary Phone: ____ cell home work other

Secondary Phone: ____ cell home work other

Email (for billing purposes): ____

Preferred Communication (Circle) PHONE MAIL EMAIL

____

<u>In case of an emergency, notify</u>:

Name: ____

Relationship: ____________________________

Phone: __________________________ cell home work

Hospital of choice: ____

*Client Name/DOB*_______________________

FINANCIALLY RESPONSIBLE PARTY (if someone other than client)

Name: ____

DOB___________________________________

Relationship to Client: ______________________________

Address (if different from client): ____

PRIMARY INSURANCE INFORMATION

Name of Insured: ____________________________________

SS# ___________________________________

DOB___________________________________

Relationship to Client: ______________________________

Insurance Company: _______________________________________

Effective Date: ______________________

Policy # ____________________________________

Group Member #: ________________________________

Co-Payment Amount: ___________________

Deductible Amount: _____________________

Phone Number for Mental Health Coverage (On back of card): ___________________________________

Employer Name/Address (only if insurance plan thru employer): _______________________________________

____

*Client Name/DOB*______________________

SECONDARY INSURANCE?   YES   or   NO

Name of Insured: ____________________________________

SS# ___________________________________

DOB___________________________________

Relationship to Client: ______________________________

Insurance Company: _______________________________________

Effective Date: ______________________

Policy # ____________________________________

Group Member #: ________________________________

Employer Name/Address (only if insurance plan thru employer): _______________________________________

____

Additional Information

Referral Source: ____

Would you like to receive our email newsletter? (Circle)   YES   NO   Like us on Facebook and Twitter!

Would you like to receive appointment reminders? (Circle all that apply)   TEXT   EMAIL   PHONE (Voice)

Cell # and/or Email for newsletter and appointment reminders if different than above:

____

____

Information for Clinicians: (FOR CLINCIANS USE ONLY)

Billing Diagnosis Code: _________________

Clinical Diagnosis Code: ________________

Any Modifying Codes: __________________

*Client Name/DOB*________________________

MEDICAL INFORMATION

Have you ever received counseling before? (Where and when?) - ____

____

Date of last physical exam: ___________________________ Height: _____________ Weight: ____________

Physician's Name/Office and Phone Number:

____

How would you describe your general health currently? ____

____

Are you taking any medications including supplements: ____

____

Are you currently being treated by a physician for any physical condition? ____

Have you had any serious illness? (Please list) ____

____

Have you ever undergone any surgery? (Please list) ____

____

*Client Name/DOB*______________________

Please mark all that currently apply for you:

___ Crying spells ___ Increased heartbeat ___ Problems with finances ___ Feeling misunderstood

___ Inability to have fun ___ Constantly worried ___ Problems with marriage ___ Headaches

___ Feelings easily hurt ___ Frequent sweating ___ Work difficulties ___ Worried about health

___ Confidence lacking ___ Feelings of dizziness ___ Sexual problems ___ Trouble concentrating

___ Constipation ___ Shaky hands ___ Struggle to keep a job ___ Struggle to "get going"

___ Feeling grouchy ___ Stomach trouble ___ Don't like to be alone ___ Loss of meaning to life

___ Constantly tired ___ Full of energy ___ Easily excited ___ Fainting spells

___ Poor appetite ___ Feeling tense ___ Loss of sexual interest ___ Phobias/strong fears

___ Feeling depressed ___ Cold feet and/or hands ___ Problems with children ___ Muscle twitching

___ Trouble sleeping ___ Feeling panicky ___ Problems with parents ___ Digestive issues

___ Feeling lonely ___ Diarrhea ___ Poor physical health ___ Quick tempered

___ Loss of weight ___ Shy with people ___ Fighting & quarreling ___ Easily angered

___ Not enjoying things ___ Struggle w/handling money ___ Feeling fearful ___ Excessively critical of oneself

___ Extremely restless ___ Impatient with people ___ Overly sensitive

___ Suicidal attempts: ___ Current ___ Past __Suicidal thoughts: ___ Current ___ Past

___ Unresolved grief ___ Feelings of guilt ___ Struggle to relax ___ Feeling anxious

___ Nausea and/or vomiting ___ Concerns with medication use ___ Currently using probiotics

___ Feelings of inferiority ___ Excessively judgmental of others ___ Struggle to make decisions

___ Nightmares ___ Struggle to make new friends ___ Desire to smash things

___ Feeling angry ___ Lacking energy ___ Injuring oneself ___ Overly ambitious

___ Concerns with alcohol/drug use ___ Concerns regarding eating habits ___ Currently taking a multi-vitamin

___ Unable to think clearly/brain fog ___ Disturbing/unreal thoughts ___ Low self-esteem

___ Desire to hurt someone ___ Others concerned about my use of alcohol/ drugs

Other (Please specify): ____

*Client Name/DOB*_______________________

GENERAL INFORAMTION

Welcome to the Rinehart Institute. You, or a member of your family, are about to engage in a counseling or psychotherapeutic relationship with a licensed/certified therapist. We are here to work with you in partnership to get the most out of your counseling experience. You will get out of the work what you are willing to put in. Making changes in our lives can be very challenging as well as very rewarding. We wish to take this time to inform you of the basic principles we believe are critical in developing a high-quality counseling relationship between us. Please read over this information and ask if any questions arise.

Fees:

Initial intake session: 45-55 minutes	$154.12
Individual session: 55 minutes	$149.56
NET remedies	$22.00
Nutritional Products	Priced individually
Court Fees	$150 per hour for appearances
Court documentation/paperwork	*Assed finically per situation*

The first visit is thought of as a diagnostic or evaluation interview. During this session, the following decisions will be made with you:

a) type of therapy to utilize (individual, couple, etc.)
b) frequency of therapy sessions (weekly, biweekly, etc.)
c) goals to work toward in therapy (what you hope to gain from this experience)

Appointments:

Before each appointment begin please check in at the front desk. Each appointment lasts approximately 45-55 minutes. At the close of each session, you may discuss future appointments with your therapist. Before leaving please see the sectary at the front desk to make any payments if necessary.

Cancellation Policy:

If you need to cancel an appointment, we require at least a 24 hours in advance notice. If you do not cancel more than 24 hours prior to your appointment, or if you do not show up at all, **a $50 fee will be automatically charged and it is required that you keep a credit/debit card on file so we can charge this fee if need be.** *If you are a **Medicaid client**, please be aware that the clinician has the right to terminate your mental health services at Rinehart if you fail to follow the cancellation policy or do not show up to an appointment.* We understand that emergencies happen and they are the exception to this policy. Please be mindful that Insurance companies will not reimburse you for missed appointments.

SEXUAL ABUSE & MISCONDUCT PROTOCOL

The Rinehart Institute prohibits and does not tolerate sexual abuse or misconduct in the workplace or during any organization-related activity. The Rinehart Institute provides procedures for employees, sub-contractor, volunteers, clients or any other victim of sexual abuse or misconduct to report such acts. Those reasonably suspected or believed to have committed sexual abuse or misconduct will be appropriately disciplined, up to and including termination of employment or association as well as criminally prosecuted. No employee, sub-contractor, volunteer, associate or client, regardless of his or her title or position has the authority to commit or allow sexual abuse or misconduct.

In the case of a sexual abuse or misconduct event, the following procedures will commence:

1. Any incident will be reported to Charlene Brown, the Clinical Director for Rinehart Institute, or Administrative Associate.
2. Charlene or the Administrative Associate, with the complainant, will complete an Incident Report.
3. The Incident Report will be followed up with an inquiry by the Sexual Abuse and Misconduct Investigative Personal.
4. Upon the completion of the inquiry, a formal summary of the investigation will be completed with recommendations for action.
5. Recommended actions will take place and if need be, proper authorities and/or other appropriate resources will be contacted to carry out the recommendations.
6. The summary of the investigation will be shared with the complainant and any other appropriate parties.

Insurance:

Most insurance companies will pay a portion of the fees for outpatient mental health services and the Rinehart Institute accepts many different insurances. It is the responsibility of the client to contact the insurance company to find out the details of their policy coverage. The Rinehart Institute will provide insurance billing services, but the client is **ultimately responsible** for all services, supplements, and supplies not covered by insurance. It is recommended that the client look over their insurance policy annually to be aware of changes or alterations to their policy.

Client Name/DOB______________________

Confidentiality:

All information regarding the specific details and nature of your counseling or psychotherapy is maintained at the Rinehart Institute and is considered confidential. We abide by HIPAA guidelines and will not release information without your written approval. A separate release will be obtained, should medical records be requested or exchanged. However, each therapist at this office reserves the right to use specialty consultation with other therapists in the office per HIPAA's "need to know" policy and "supervision" guidelines.

PLEASE SIGN BELOW*. If more than one adult patient, each person should check and initial the boxes below.*

__ Yes __ No I acknowledge that I have read and understand all of the statements above and my signature below indicates that I agree with said statements.

__ Yes __ No I authorize the release of any medical information necessary to process the insurance claim. I permit a copy, or other facsimile reproduction, to be used in place of the original. I request that payment by my insurance company be made directly to the Rinehart Institute. I certify that the information I have reported is correct.

__ Yes __ No I have received a copy of the patient information and the HIPPA Privacy Practices.
__ Yes __ No I have received a copy of the Sexual Abuse & Misconduct Protocol.

Client or Guardian signature

____

Date_____________

Therapist's Signature

____

Date______________

*Client Name/DOB*________________________

CREDIT CARD / HSA AUTHORIZATION POLICY

Rinehart Institute is requesting that **all clients have a credit card on file**. This is for security purposes as a business. You do not have to make payments with the credit card on file, payments can be made in any monetary form. The credit card on file will only be charged in the event of a NO SHOW FEEE or for collections.
All credit card information will be stored in Rinehart Institute's secure online patient management system for security purposes. Clients can also access their secure credit cards online if they are interested in making any payments towards self-pay fees, insurance deductibles, co-payments, net remedies, or supplements.

You will have the option to make payments with a credit card even if you do not keep one on file, but you will need to provide the credit card information every time a payment is processed.

Client Name: ____

Cardholder Name (if different than client): ____

Card Number: ____

Expiration Date: ___________________

CSV Code: ___________________

Billing Address: ____

____

In signing this document, I am authorizing The Rinehart Institute to process payments for the above-mentioned reasons.

Signature: ____

Date: ______________________

*Client Name/DOB*______________________

RINEHART INSTITUTE PAYMENT AGREEMENT FORM

DATE: ________________

CLINICAN: _______________

This payment agreement dated___________, made between Rinehart Institute and ________________________. By signing this document, you agree to the flowing payment installments:

Payments will set forth on ____________ and payments will be repaid in full by_________________. The payee may make payments before scheduled date without any penalty. Payments will be made every two weeks from the start date stated above.

Failure to make payments will enact our three-call policy. Rinehart will make one phone call once a week for three weeks following the first missed payment. If no payment or contact from payee is received in that time, the payee will be sent to collections and they will be liable for any/all additional collection fees.

Total amount owed: _____________

Scheduled payments:

Payment 1: _________________

Payment 2: _________________

Payment 3: _________________

Payment 4: _________________

Payment 5: __________________

Payment 6: __________________

Phone call 1: ______________

Phone call 2: ______________

Phone call 3: _______________

Print Name: _____________________________________

Signature: ______________________________________ Date: ___________

Witness Signature: _________________________________ Date: _____________

Rinehart Institute
2047 W. Main St.
Kalamazoo MI 49006

Phone: 269-381-8191
Email: rinehartinstitute98@gmail.com
Fax: 269-312-8827

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We will never share any subtance abuse or alcohol/drug counseling records without prior written consent or a Special Court Order.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: July 1, 2016

This Notice of Privacy Practices applies to the following organizations.

The Rinehart Institute Only.

The HIPAA Privacy Officer for the Rinehart Institute is Rose Hathaway 269-8191 and her email is rinehartinstitute98@gmail.com