Healing & Refuge Centre', LLC
E. LaMonica Williams, MSW, LSCSW
250. N. Rock Rd. Suite 300F
Wichita, Ks

REGISTRATION

Date:_____

PERSONAL INFORMATION **(indicate with a star the preferred way to contact you)**

Name:_____ Date of birth: _____

Address:_____ Employer:_____

City:_____ State_____ Zip_____ Email:_____

Home Phone _____ Work Phone:_____

Circle Status: single married Domestic Partner Cell Phone: _____

Referred to me by:_____

RESPONSIBLE PARTY (If client is a minor)

Parent Name:_____ Spouse Name_____

Address: _____
(If different than above)
City/Zip:_____

Primary Insurance:_____ ID#_____
Group#_____ Date of Birth:_____
Policy Holder's Address if diferent from client:_____
Policy Holder's Phone number if different from client:_____
Policy Holder's Social Security Number:_____
Policy Holder's Employer:_____

Secondary Insurance: _____ ID#_____
Group#_____ Date of Birth:_____
Policy Holder's Address if diferent from client:_____
Policy Holder's Phone number if different from client:_____
Policy Holder's Social Security Number:_____
Policy Holder's Employer:_____

Parent Name:_____ Spouse Name: _____

Address: _____
(If different than above)
City/Zip:_____

Business Phone:_____

Home Phone:_____ Cell Phone:_____

EMERGENCY CONTACT
Name:_____ Cell Phone:_____

Home Phone:_____ Business Phone:_____

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HEALTH HISTORY/CLIENT INTAKE FORM

Name_____

Allergies: _____ _____

Psychiatrist or treating Dr.: _____

Current Medications:
Med. _____ Dose (mg) _____ Times/day_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Include any other medications on the back of this sheet:
Do you currently use any of the following?

Caffeine:
Coffee amount/day: _____ Tea amount/day:_____ Soft drinks: amount/day_____

Alcohol:
Beer: amount_____ per (circle one) day, week, month
Mixed drinks/neat (amount in ounces of alcohol) _____ per day, week, month

Drugs:
Marijuana amount _____ per (circle one) day, week, month

Stimulants:
Cocaine, Methamphetamine, etc. amount_____ per day, week, month

Other drugs: List type, frequency, and amount _____
_____

Have you ever received treatment for addictions? When/Where _____

Cigarettes, cigars, chew tobacco, snuff amount _____ per day, week, month,

Head injuries:

Falls, accidents where you hit your head: explain _____
Concussions, closed head injuries, head injuries: _____

Did you ever play football_____ other contact sport _____
Have you ever lost consciousness? Explain _____

Used any inhalants, exposed to toxic materials _____

Hospitalizations/surgeries:

Age: _____ Reason _____

Age_____ Reason _____

Check any of the below symptoms if you have had them within the last 6 months:

_____ Headaches, neck pain
_____ Back pain
_____ Shortness of breath/pressure in chest
_____ Pounding heart/fluttering
_____ Recent gain/loss of weight
_____ Indigestion/bowel problems
_____ Epilepsy/seizures
_____ Vision problems
_____ Memory loss/ increased forgetfulness
_____ Eating problems (restricting, overeating)
_____ Anxiety attacks/nervousness
_____ Fatigue/more tired
_____ Skin problems
_____ OB/GYN problems
_____ Worrying/obsessing
_____ Phobias, fears
_____ Anger/rages

Sleep problems, describe _____

Other physical problems that you are concerned about: _____

Trauma: Have you experienced any of the following?
Sexual abuse, assault (ages) _____

Physical abuse, domestic violence, assault (ages)_____

Accidents, incidents that were traumatic _____

Have you ever witnessed a traumatic event? _____

Do you have any of the following? Please check.
____ Diabetes
____ Heart problems: list_____
____ Asthma
____ Bipolar
____ Depression
____ Thyroid: list_____

____ Addictions: List_____

____ Learning disabilities _____

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Wichita, Ks 67206

Client Name: _____

CONSENT FORM

Please read and initial after each.

Kansas law (KSA 65-6319) requires that I inform you of my level of training. Your initial below indicates that you understand the following: I am a Master's Level Social Worker (MSW) who is licensed by the State of Kansas. I am licensed to provide independent psychotherapy in private practice (LSCSW). Social Workers can diagnose and treat disorders listed in the current diagnostic manual (DSM-IV). I cannot prescribe medication.

_____
Initials

Kansas law (KSA 65-6306) requires that " When a client has symptoms of a mental disorder, a Licensed Specialist Clinical Social Worker (LSCSW) can consult with client's primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms of a mental disorder". **You have the right to agree with or decline this consultation with your doctor.** Please initial **only one** of the 2 choices below.

1. _____ **I agree** to allow E. LaMonica Williams, MSW, LSCSW to consult with my primary care physician or psychiatrist about my condition
_____ **Physician Name**

_____ **Physician Address**

_____

_____ **Physician Phone Number**

OR

2. ____ **I decline** to allow E. LaMonica Williams, MSW, LSCSW to consult with my primary care physician or psychiatrist about my condition.

_____
Date

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PSYCHOTHERAPY PRACTICE POLICIES:

PAYMENT POLICIES

Payment is due at the time of service. Make checks payable to "E. LaMonica Williams" No balances will be carried over from month to month. This is a common business practice and it keeps everyone on good terms. I accept cash, and personal checks.

You are responsible for any charges that insurance companies do not pay. I recommend that you become familiar with your health care coverage and it's limitations before you start treatment.

I expect you to keep track of what your insurance pays and what your co-pay is each session. That way you will not run up a balance. My Rate is $120.00 per session I charge $150.00 for the first evaluation session.

OFFICE HOURS

All appointments are prescheduled with E. LaMonica Williams.

CANCELLATIONS/MISSED APPOINTMENTS

Cancellations (with less than 24 hours notice) and missed appointments will be billed at $60.00 (Acts of nature, accidents, and hospitalizations will be forgiven). Your insurance company will not pay for missed appointments.

BILLING:

My billing service will bill your insurance company for you and send you a monthly bill. You are responsible for any charges not covered by insurance. My billing service is aware of privacy laws and will only release a diagnosis, your address, phone number, insurance information from your card, dates of service and type of service provided, to your insurance company. All information is kept confidential.

INSURANCE PAYMENTS:

Insurance companies pay me directly after the claim is processed. Insurance companies do not guarantee that they will pay for services. These decisions are made after the claims are sent and processed. Insurance companies pay for diagnosable conditions that they call of "medical necessity". They can deny payment for many reasons. You can appeal any denial using the insurance company's appeal process.

Your insurance company sends you an explanation of benefits (EOB) when they pay me or pay you. Insurance companies make many mistakes (over 30% of the time) and if your EOB looks incorrect, call your insurance company and find out what the problem may be.

PRIVACY AND RELEASE OF INFORMATION:

All claims sent to an insurance company require a diagnosis. Signing the insurance form gives me permission to give your insurance company a diagnosis. HMO plans require that I fill out a treatment plan or talk to a case manager. I can provide you with a copy of the form that I send to them. Your diagnosis may be sent to the Medical Information Data Bank (by the insurance companies) to which all insurance companies have access. Some mental health diagnosis may limit future insurance options such as long term disability applications.

I cannot guarantee your privacy when I submit a claim to health insurance companies. Once I release information to them it is handled according to their privacy policies.

CONFIDENTIALITY:

Your records and time spent with me is considered confidential. That means that I have possession of your records and cannot release any information about you without your written permission.

All confidentiality policies are listed on the HIPAA form that you sign with your paperwork. You can have a copy of the HIPAA form for your records.

RECORDS:

I keep a file on every client. I am not allowed to destroy medical records for up to 10 years. I keep current client files in my office in a locked cabinet. No one but me has access to the cabinet. After treatment is completed, I store them outside the office. After 10 years I shred charts with a bonded shredding service. Credit card receipts will be shredded at the end of each calendar year or at termination of treatment.

EMERGENCIES:

Clinical Social Work is not a medical practice. I can assist you in all kinds of life issues.

You are responsible for your life and responsible for your therapy. My role is to provide support, information, an objective perspective, and hope for a better life. I will do what I can to help you achieve your goals.

I cannot, however, be responsible for your day-to-day functioning on a 24 hour basis. If 24 hour care is needed, there are resources that can get you through a crisis such as emergency rooms, crisis lines, day hospital programs, hospitals, family supervision, group homes, etc.

I provide an emergency phone number to call on my voice mail if you have an emergency.

MY AVAILIABLITY:

I am available during office hours for crisis intervention, assistance, and counseling sessions. Evenings and weekends are reserved for me to rejuvenate myself. Studies show that therapists function better for their clients when they live a balanced life, have time away from work, develop self awareness, and have support from colleagues, friends, and family.

I also want to let you know that I travel professionally throughout the year and may be unavailable at times. I will leave a name and number of someone to cover for me on my voice mail.

Let's discuss what your needs are and make a plan that fits you if an emergency arises.

Notice of Social Worker's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
- *Adult and Domestic Abuse* – If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
- *Health Oversight Activities* – I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose

information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.

- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Social Worker's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Social Worker's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will give you a copy next time I see you or mail it to you.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Department of Health and Human Services at 877-696-6775.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The number listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or give you a copy at out next session.

Your signature below acknowledges that you have received a copy, read and understand this Notice. You may at any time ask any questions about this Notice.

Signature: _____ Date: _____