BEFORE YOUR FIRST APPOINTMENT

If you choose to use your health insurance, you must call your insurance company prior to the first appointment. Please ask the following questions to the **Mental /Behavioral Health Division** representative so that all of the billing information is complete. If your claims are denied due to "no authorization," you will be responsible for any balance due. Payment is required on your copay, and/or unmet deductible amounts, at the time of your visit.

My appointment with _____ on _____ at _____

1. Do I need an authorization for counseling sessions? Yes ___ No ___
2. If so, what is my authorization number? _____
3. How many sessions are allowed for this authorization? _____
4. What is my copay amount? _____ Do I have a deductible? _____
   What is my unmet deductible amount? _____
6. Are these services under an Employee Assistance Program (EAP)? _____
7. What is the billing address for claims?

_____

Please feel free to contact our office at 740-587-5252, with any questions.

THANK YOU

Newark-Granville Psychological & Counseling Services, Ltd.

Client Information

Client Name:_____ Date of Birth: _____

Address: _____
Street City State Zip

Sex: Male Female Social Security Number: _____

Telephone Number: Home (____)_____ Cell: (___)_____

Work (____)_____ Ext: _____

If necessary, may we call you at work if we do not identify ourselves? YES NO

Responsible Party

Name: _____ Relationship to client: _____

Address: _____
Street City State Zip

Primary Insurance Policy

Insurance Company: _____

Employer's Name: _____

Name of Insured: _____ Insured's Social Security Number: _____

Insured's Identification Number:_____ Insured's Date of Birth:_____

Client's relationship to insured: Self:_____ Spouse:_____ Child:_____ Other:___

Secondary Insurance Policy

Insurance Company: _____

Employer's Name: _____

Name of Insured: _____ Insured's Social Security Number: _____

Insured's Identification Number:_____ Insured's Date of Birth:_____

Client's relationship to insured: Self:_____ Spouse:_____ Child:_____ Other_____

Assignment of Benefits and Release of Information

I authorize NGPCS to release information necessary to effect treatment and claims payment. I also authorize payment of medical benefits be made directly to the provider.

Signed: _____ Date:_____

Telephone Consumer Protection Act (TCPA)

I authorize a representative of NGPCS and/or any entity authorized by NGPCS, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Email address:_____

Signed:_____ Date:_____

Consent to Treat

I agree to mental health and/or alcohol and drug treatment as offered by NGPCS for:

_____Myself _____My Child _____The person for whom I am legal guardian

_____Myself, being a minor child 14 years or older

I acknowledge this consent is voluntary and does not include medication/somatic (psychiatric) services.

I give consent for the use of my protected health information for treatment and payment as described in the Notice of Privacy Practices.

I further acknowledge I may revoke, in writing, this consent any time except to the extent that action based on this consent has already been taken.

Signature:_____ **Witness Signature:**_____

Date:_____ **Date:**_____

Emergency Contact

In case of emergency contact _____ at _____

NEWARK-GRANVILLE PSYCHOLOGICAL AND COUNSELING SERVICES, LTD.
Office and Financial Policy

Welcome to Newark-Granville Psychological and Counseling Services, a safe place to grow. We are pleased that you have selected us to aid you to a healthier life. We want to make your visits as easy as possible by providing information that will help you with our billing and office procedures. Feel free to discuss any concerns you have with your therapist.

Please be sure to bring these items with you for each session:

Insurance Cards
Payment such as cash, check or credit card

We may not be able to see you if you do not bring these items.

If you need to cancel or reschedule an appointment, contact our office at least 24 hours in advance. You may leave a message on your therapist's confidential voice mail or with the office manager. We reserve the right to charge $50.00 if we are not notified 24 hours in advance. If you miss an appointment without notice, a rescheduled appointment can not be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a client.

You need to be sure any authorizations for treatment are provided to us at your first visit. Your visit may be rescheduled, or you may be charged the full amount for the service if you do not provide this information.

At the time of each visit, you are responsible to pay any deductible, copayment, or outstanding balance. Payment may be made with cash, check or credit card. We accept MasterCard, Visa or Discover. There is a fee of $32.00 for checks returned by your bank for any reason. In the case of overdue accounts, interest may be charged when the bill is delinquent. We reserve the right to turn the account over to a collection agency. You will receive notification from us prior to collection action with ample time to pay your bill. As is permitted under law, we will release your name, address, and the amount owed, should the delinquency continue.

Are there any considerations I need to know before entering into the counseling process?

The treatment process will be most helpful to you when you are honest and trust the process. We honor your presence and will work with you to make this a beneficial experience.

How long does each appointment take and how long will I be in counseling?

Appointments can be anywhere from 45 to 60-minute sessions. Your individual needs are determined by you and your therapist and will dictate the frequency of appointments and the treatment duration.

How can I be assured that my records are confidential?

State and Federal laws govern that your records are confidential. We release information with your signed permission. Please be aware of several rare exceptions to confidentiality. In situations of possible harm to you or another, suspected child abuse or neglect, or when a court subpoenas your records, your therapist may be required to release confidential material. You should be aware all insurance companies require a clinical diagnosis. Sometimes we have to provide additional information such as a treatment plan or summaries, or copies of the entire record (in rare instances). This information becomes part of the insurance company files. While the insurance companies do have to follow the same practices as we do regarding confidentiality, we have no control over what they do with your records. We will be glad to share with you any information released to your insurance company. Please refer to the Notice of Privacy Practices for additional information.

What if I want to switch therapists?

We believe that you, as a consumer, need to be comfortable with services provided. If you would like a different therapist, please discuss this in treatment. It is important that you have a therapist that meets your needs.

How does the billing work?

NGPCS contracts with many insurance companies. If you have insurance with one of these companies, our outside billing company, Paumier Medical Management Group, Inc.(PMMG), will submit a claim on your behalf. The initial office visit fee for psychological/counseling services is $185; continuing appointments are $170 for a 60 minute session, $160 for a 45 minute family session and $145 for a 45 minute individual session. If your insurance does not pay or partially pays, you will be responsible for the balance. Your insurance company should send you an explanation of benefits explaining to you how the claim was processed. PMMG sends out statements reflecting services and balances. All our fees are subject to change.

What if I have an emergency that can't wait until my next appointment?

If you call our office during regular business hours, we will try to have an available therapist respond to your needs. If there is not an available therapist, or if you have an emergency after business hours, please call 911 or the Crisis Line 345-4357 (345-HELP), or go to the nearest emergency room.

Will I be charged for telephone calls?

There is no charge for the initial 10 minutes of a phone call to your therapist. After 10 minutes, your charge will be prorated at our regular hourly fee. Most insurance companies do not cover telephone calls.

Will there be any additional costs?

Time spent on your behalf outside of counseling sessions (e.g. school consultation, court appearances, court preparations, hospitalization arrangement, etc.) result in an additional prorated billing. Routine letter writing or reports on behalf of the client will be subject to $80/hr fee. Court related time, as outlined in "Court Related Services", constitute additional fees. **Payment is expected prior to the court appearance and/or any documents being released.** Please allow 10 business days for turn around time for reports, forms and letters written on your behalf.

Are there special considerations if I am bringing my child for treatment?

If the client is a minor, a custodial parent must sign a permission form authorizing services. Oftentimes the therapist will need to obtain background information from the parent to aid in the treatment process. The therapist will explain to you and your child how confidentiality works in such cases. The sessions may be divided to allow for parental consultation time. Your therapist will discuss this with you. In the case of divorce, both parents will be considered equally responsible for payment. Whoever brings the child to the office is responsible for payment at the time of the visit.

Thank you for reading this information. If you have questions about these or other matters, now or during your treatment course, please discuss them with your therapist. Dealing with these issues is often an important part of treatment. We look forward to meeting with you. If you would like a copy of these office policies for your records, please ask our Office Manager.

I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.

_____ _____

Signature of Client or Legal Guardian Date

Newark-Granville Psychological and Counseling Services, Ltd.

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, that patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment, or to a collection agency if necessary.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and discloses will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information. **Protected health information** covers any identifiable information in the file, information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, and certain information used for research situations. You can exercise your rights by presenting a written request to the Privacy Officer, Cheryl Meisterman, Ph.D., LISW, (740) 587-5252.

You have the right to:

- Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- Inspect and copy your protected health information.
- Amend your protected health information.
- Receive an accounting of disclosures of protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Any individual or others filing a complaint will not be intimidated, coerced, threatened or discriminated against, provided the individual(s) is acting in good faith, believe the practice opposed is unlawful, and the manner of opposition is reasonable, involving the disclosure of protected health information.

Please contact us for more information:

Cheryl Meisterman, Ph.D., LISW
Privacy Officer
Newark-Granville Psych. & Counsel.
945 River Rd
Granville, OH 43023-9169
(740) 587-5252

For more information about HIPAA or to file a complaint:

The US Department of Health/Human Services
Office of Civil Rights
200 Independence Ave., SW
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Newark-Granville Psychological and Counseling Services, Ltd.

945 River Rd, Granville, OH 43023-9169

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Client Name: _____

Relationship to client: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

Revised 2015

CLIENT QUESTIONNAIRE

We are pleased that you have decided to make an appointment at Newark-Granville Psychological and Counseling Services. Please complete the following with as much detail as you are comfortable. If necessary, you may attach additional sheets. The information is confidential and will save time in the early appointments.

Name _____ Today's Date _____

Age _____ Marital Status _____Who referred you to our office? _____

Please list name, relationship, and age of other household members:

1)_____

2)_____

3)_____

4)_____

Please list all current medications, including over the counter medications and supplements:

Medication Name:_____Dosage and frequency:_____

Reason for medication:_____How long used?_____

Medication Name:_____Dosage and frequency:_____

Reason for medication:_____How long used?_____

Medication Name:_____Dosage and frequency:_____

Reason for medication:_____How long used?_____

Medication Name:_____Dosage and frequency:_____

Reason for medication:_____How long used?_____

Describe the reasons for making this appointment: _____
_____
_____

How long have you had these concerns? _____

What have you tried to help with these difficulties? _____

List recent stressful events: _____
_____

Do you have cultural, ethnic, or religious needs that may impact treatment? _____

What are your major sources of emotional support? _____
_____

_____

How would you consider your present health? _____

What is the date of your last physical exam? _____List any medical problems you have encountered:
_____
_____

List any allergies, including medications: _____

List the date and type of in-patient and out-patient hospitalizations or surgeries you have experienced:

Date: _____ Reason:_____

Date: _____ Reason: _____

Date: _____ Reason: _____

Please list all substance abuse and mental health treatments:

Date: _____ Facility: _____

Reason: _____ Helpful? Yes / No

Date: _____ Facility: _____

Reason: _____ Helpful? Yes / No

Date: _____ Facility: _____

Reason: _____ Helpful? Yes / No

Please indicate your usage of the following substances:

	Date last used:	How often:
Alcohol	_____	_____
Marijuana	_____	_____
Tobacco	_____	_____
Cocaine	_____	_____
Caffeine	_____	_____
Ecstasy	_____	_____
Codeine	_____	_____
Steroids	_____	_____
Inhalants	_____	_____
Stimulants/Amphetamines	_____	_____
Sedatives	_____	_____
Opiates	_____	_____

Please check the following that apply to you:

___ Numbness or tingling
___ Racing heart, palpitations
___ Nausea, diarrhea, stomach pain
___ Excessive sweating, moist palms
___ Headaches, body aches
___ Worry a lot
___ Lose temper easily
___ Difficulty concentrating
___ Memory problems
___ Difficulty sleeping
___ Appetite low / high (circle the one that applies)
___ Feeling hopeless
___ Excessive exercise
___ Self-induced vomiting
___ Excessive hand washing, fear of germs
___ Excessive checking (doors, locks, etc.)
___ Inability to throw things away
___ Failure to complete chores or homework
___ Make careless mistakes regularly
___ Impulsive
___ Sexual problems
___ Fear of criticism or fear of being embarrassed
___Shortness of breath
___Dizziness, blackouts
___Hot flashes, chills
___Feeling shaky, twitchy
___Startle easily
___Road rage
___Feeling edgy, restless
___Confusion, indecisiveness
___Fatigued easily
___Sleeping too much
___Lost interest in usual activities
___ Binge eating
___ Dieting
___ Using laxatives or diuretics to lose weight
___ Excessive need for order or counting things
___ Forgetful in day-to-day activities
___ Fidget a lot
___ Overspending or gambling
___ Shame

Age of father :_____(If deceased, age when died and cause of death)
Father's occupation _____

Age of mother:_____ (If deceased, age when died and cause of death)
Mother's occupation _____

Are/were your parents divorced? _____ What age were you when they divorced? _____

Who lived in your home when you were growing up? _____
_____

Did you have step-parents and/or a blended family? Please explain: _____
_____
_____

List all of your siblings, their ages and their occupations: _____
_____
_____

List any medical problems, including substance abuse and psychiatric issues that run in your family:
_____
_____

Briefly describe major stresses in your childhood, including exposure to violence:
_____
_____

Do you have a history of being abused: physical, sexual, emotional or verbal? _____

List any school concerns you had as a child, including special services, repeated grades, or behavior issues:_____

Please list any marriages, and the dates of the marriages: _____

Please list any children you have and their ages: _____
_____

If any significant others have died, please list them and the cause and date of their deaths:_____
_____

Describe your relationship with your significant other: _____
_____

Highest grade or degree completed: _____

Current occupation: _____ Military Service: _____

How long at your present job? _____ Describe any current work concerns: _____
_____

Briefly describe your work history, prior to the current position: _____

Are you currently on social media? _____ How often and for how long?_____

Do you participate in online gambling or playing games?_____

Describe difficulties with friends, past or present: _____
_____

List any legal issues you have encountered:_____
_____

What do you consider your greatest accomplishments? _____
_____

What do you consider your greatest disappointments? _____
_____

What would you like to have happen as a result of participating in counseling? _____
_____
_____
_____

Thank you. We look forward to working with you.