INTAKE INFORMATION

Name: _____

Address: _____

_____

Phone: _____ DOB: _____

Social Security #: _____ Gender: ○male ○female

Parent/Guardian if applicable: _____

Parent address if different from client: _____

_____

Current medication(s): _____

For what condition(s)?: _____

Emergency Contact Information: Name: _____

Relationship to client: _____ Phone: _____

Have you had therapy in the past? ○no ○yes

If so, when? _____ With whom? _____

For what reason? _____

What therapy goals would you like to work on? _____

_____

_____

_____

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BILLING INFORMATION

Responsible party: _____

Address: _____

_____

Contact phone number: _____

Therapy will be paid by (check one): ☐ Insurance ☐ Cash/Self-Pay ☐ Other (CSA)

INSURANCE INFORMATION

Insurance Company Name: _____

Employer: _____

Last Name: _____ First Name: _____

DOB: _____ Gender: ◯ male ◯ female

Relation to Client: ◯ Self ◯ Spouse ◯ Child ◯ Other

ID#: _____ Group #: _____

# of Visits Authorized: _____ Co-Pay for each session: $_____

I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services given. I have read all the information provided by Creative Therapy Services, LLC in regards to policies and expectations. I have completed all the above answers and certify that the information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

I, the undersigned client or legal guardian of the client, hereby authorize and direct the above insurance carrier to make checks or payments for clinical/medical expenses incurred by me directly payable to my attending clinician and associative practice. I also authorize the releases of any information regarding my medical condition or treatment to said insurance carrier and to any; third party account collection or administrators as may be necessary for billing and collection purposes. I further understand that I am responsible for all clinical/medical expenses and agree to any expenses not covered by my insurance. I understand and acknowledge that if my insurance carrier has paid or reflected payment I am responsible for the payment of the entire remaining balance.

_____ _____

Responsible Party signature Date

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CREATIVE THERAPY SERVICES
214 N. EAST STREET
SUITE 210
CULPEPER, VIRGINIA 22701

Dear Client,

In order to use insurance and understand what will be paid for by insurance, and what will not, it is important to make sure you know exactly what benefits you have. It is also important that you get treatment authorized in advance, if needed. Please call your insurance company before your first visit and get as much of the information below as possible. Please bring this information to our first meeting.

Thank you!

What are your Behavioral Health Benefits?

Co-pay per visit (what you are responsible for paying): _____

Number of visits per year: _____

When does your benefit year start and stop? Is it on a calendar year, or based upon when you start treatment? _____

Is there an annual deductible to meet, and if so, have you met it? _____

Creative Therapy Services, LLC • Lindy Swimm, LCSW
16289 Mande Lane • Culpeper, Virginia 22701

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ DOB: _____

I give permission for my therapist Lindy L. Swimm, LCSW to exchange written and verbal information with:

Name: _____

Address: _____

Phone: _____ Fax: _____

Relationship to Client: _____

I authorize the release of the following Protected Health Information (PHI):

- ☐ Initial Assessment/Diagnosis
- ☐ Evaluations (including testing)
- ☐ Medication/Medical Records
- ☐ Other *(specify)* _____
- ☐ Progress Notes
- ☐ Therapy Progression
- ☐ Legal

This authorization will expire one year from the date of the signature below unless otherwise specified or revoked prior to that date: _____

I understand that this consent can be revoked or amended at any time, unless the information has already been used or distributed. The request must be in writing to the clinician, as allowed by law.

Once PHI has been disclosed, the clinician has no control over it or how it may be used. The recipient might re-disclose it and in some instances, privacy laws may not protect your information. We will make every reasonable effort to protect your information and advise the recipient of your right to protect your PHI.

_____ _____
Signature of Client or Legal Guardian Date

_____
Name of Client

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CHILD OUTPATIENT HISTORY

CLIENT:_____ **DOB:** _____

PROVIDER: Lindy Swimm, LCSW

DATE COMPLETED: _____

DATE CASE OPENED: _____

Presenting Problem/Chief Complaint:

I. Quantify and describe specific behaviors as clinically indicated:

Describe Current Living Situation:

Describe Current School/Employment Situation:

II. History of Presenting Problem:

Document longstanding nature/date symptoms first noticed:

III. Previous Treatment:

Response to Previous Treatment:

IV. ANY PREVIOUS DSM IV Diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Level of Stress: _____

Axis V: _____

Current GAF: _____ Highest Past Year: _____

V. Family History:

VI. Developmental History: *(prenatal/perinatal, developmental milestones and/or delays)*

☐ **Physical:**

☐ **Psychological:**

☐ **Social:**

☐ **Intellectual:**

☐ **Academic:**

VII. Legal History: (Court involvement, Social Services, divorce issues, visitation, etc.)

VIII. Substance Abuse History (including alcohol and cigarettes) :

☐ **Active/Chronic:**
☐ **Historical:**
☐ **No concerns known**

IX. History of Trauma/Abuse:

☐ **Witness to violence**
- ☐ **Domestic:**
- ☐ **Outside the home:**

☐ **Victim of violence**
- ☐ **Domestic:**
- ☐ **Outside the home:**

☐ **Other—specify:**

☐ **No concerns known**

X. Mental Status: (Place **X** by all that apply)

1. Intelligence ☐ within the average range ☐ significantly below average ☐ significantly above average	2. Behavior ☐ uncooperative ☐ anxious ☐ overly submissive ☐ friendly and cooperative	3. Movement ☐ accelerated, restless ☐ decreased, slowed ☐ atypical, peculiar ☐ well controlled
4. Mood ☐ incongruent with though ☐ blunted, flat ☐ euphoric ☐ angry, hostile ☐ labile ☐ within normal limits	5. Perception ☐ auditory hallucinations ☐ visual hallucinations ☐ other type of hallucination ☐ none of the above	6. Thought processes, content: ☐ impaired judgment ☐ impaired attention ☐ impaired stream of thought ☐ delusions ☐ suicidal ideations ☐ homicidal ideation ☐ paranoid ideation ☐ within average limits
7. Orientation ☐ disoriented to person ☐ disorient to place ☐ disoriented to time ☐ oriented on all 3 spheres	8. Memory ☐ impaired immediate recall ☐ impaired recent memory ☐ impaired remote memory ☐ memory functions intact	9. Level of Risk ☐ High ☐ Medium ☐ Low ☐ None

XI. What goals would you like to achieve in treatment?

_____ _____

Signature **Date**

AUTHORIZATIONS OF CLINICAL TREATMENT

Consent for Treatment

I, _____ give consent for Creative Therapy Services to provide treatment to me, my child, and/or my family. I am aware of the therapeutic expectations, my rights, and responsibilities.

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

I hereby acknowledge that I have been given the opportunity to read and receive a copy of Creative Therapy Services' Notice of Privacy Practices. I understand that if I have any questions, I may consult my therapist.

Missed Appointments

I understand that I must cancel my appointment 24 hours in advance. I understand that if I do not cancel, I will receive a cancellation fee bill for the therapy time missed.

Freedom of Choice of Provider

I am aware that I have the right to choose my own therapist. If at any time, I wish to discontinue therapy, I can discuss this with my therapist and either my therapist will respond to my concerns or make an appropriate referral for me.

Right to Records

Clinical records contain information about clients seeking therapy, their treatment goals, a social and medical history, and a payment history. At times, records also contain other information sent by collaborating professionals. Clients may review and/or receive a copy of their records unless the therapist believes it will be harmful for records to be released. Please refer the HIPPA information for further details.

_____ _____

Signature of Client/Legal Guardian Date

NOTICE OF PRIVACY PRACTICES

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

I. Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

Protected Health Information (PHI) means health information (including identifying information about you) that we have collected from you or received from your health care providers, health plans, employer or a health care clearinghouse. It may include information about your past, present or future physical or mental health condition, the provision of your health care, and payment for your health care services.

We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We are also required to comply with the terms of our current Notice of Privacy Practices.

II. Confidentiality

As a rule, we will disclose no information about you, or the fact that you are our patient, without your written consent. Mental health records describe the services provided to you and contains dates of our sessions, treatment goals and objectives, information you gave your therapist at intake, and payment records.

Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. We not routinely disclose information in such circumstances, so we will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time.

III. Limits of Confidentiality

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your PHI without authorization for the following additional purposes, either because of policy or because legally required:

Child Abuse Reporting - If we have reason to suspect that a child is abused or neglected, we are required by Virginia law to report the matter immediately to the Virginia Department of Social Services.

Adult Abuse Reporting - If we have reason to suspect that an elderly or incapacitated adult is abused, neglected, or exploited, we are required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of
Welfare or Social Services.

Court Proceedings - We may disclose health information about you to a court or administrative agency when a judge orders us to do so.

Serious Threat to Health or Safety - Under Virginia law, if we are engaged in our professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we are legally required to take steps to protect third parties.

These precautions may include (1) warning the potential victim(s) or the parent or guardian of the potential victim(s), if under 18, (2) notifying a law enforcement officer, or (3) seeking your hospitalization. We may also use and disclose health information about you when necessary to prevent an immediate, serious threat to your own health and safety to you, your employer, the insurer, or a certified rehabilitation provider.

Records of Minors - Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child.

IV. Your Rights Regarding Your Health Information

Right to Request Restrictions - You have the right to request restrictions on the health information we use or disclose about you for treatment, payment, or health care operations. To request a restriction, you must make the request in writing addressed to your therapist. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted information is needed to provide you with emergency treatment.

Right to Request Confidential Communications - You have the right to request that we communicate with you about your health care only in a certain location or through a certain method.

Right to an Accounting of Disclosures - You have the right to receive an accounting of disclosures of PHI for which you have neither provided consent or authorization (as described in section III of this Notice). To request an accounting of disclosures, you must submit your request in writing to your therapist.

Right to Inspect and Copy - In most cases, you have the right to inspect and copy health information used to make decisions about your care, whether they are decisions about your treatment or the payment for your care. Usually, this would include clinical and billing records, but not psychotherapy notes if this would be clinically contraindicated as determined by the therapist. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, and supplies associated with your request.

Right to Amend - For as long as your therapist keeps records about you, you have the right to request us to amend any health information used to make decisions about your care, whether they are decisions about your treatment or payment for your care. Usually this would include clinical and billing records, but not psychotherapy notes if we determine that this would be clinically contraindicated. We may also deny your request if you ask us to amend health information that: 1) was not created by us, unless the person or entity that created the health information is no longer available to make the amendment; 2) is not part of the health information we maintain to make decisions about your care; 3) is not part of the health information that you would be permitted to inspect or copy; or 4) is accurate and complete.

Right to a Copy of This Notice - You have the right to a paper copy of this Notice of Privacy Practices at any time. We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. A new copy will be given to you or posted in the waiting room.

Complaints - If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Please save and email to lindyswimm@gmail.com or fax to 888-567-1881