New Heights Counseling Services

Client Information Form

First Appointment: _____ Today's Date: _____

Client Information			
Last Name	First Name		Initial
Address	City	Sate	Zip
Home Phone	Cell Phone	Work Phone	
Is it okay to leave a voicemail and or message with someone at the above number ☐ Yes ☐ No If yes, which number above ☐ Home ☐ Cell ☐ Work			
Date of Birth	Sex ☐ Male ☐ Female ☐ Other		
Soc. Sec. Num.	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other		
Employer Name	School Name (If Student)		

In the event of an emergency New Heights Counseling Services has permission to contact:

_____ _____ at _____

Name Relationship Phone Number

Responsible Party Personal Information (Guarantor) (Do not complete this section if the Responsible Party information is the same as client information)			
Last Name	First Name		Initial
Address	City	Sate	Zip
Home Phone	Cell Phone	Work Phone	
Is it okay to leave a voicemail and or message with someone at the above number ☐ Yes ☐ No If yes, which number above ☐ Home ☐ Cell ☐ Work			
Date of Birth	Sex ☐ Male ☐ Female ☐ Other		
Soc. Sec. Num.	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other		
Employer Name	School Name (If Student)		

New Heights Counseling Services

Client Information Form

Primary Insurance Information (You must complete this section and present a copy of your insurance car for insurance to be billed)			
Insurance Company		Phone Number	
Relationship to Client		Employer	
ID Number		Group / Policy Number	
Subscriber Last Name	Subscriber First Name		Subscriber Initial
Subscriber Address	Subscriber City	Subscriber Sate	Subscriber Zip
Subscriber Home Phone	Subscriber Work Phone	Subscriber Date of Birth	
Subscriber Soc. Sec. Num.	Sex ☐ Male ☐ Female ☐ Other		

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly my counselor. I further understand that I am responsible for paying any deductible or co-pay (where applicable).

_____ _____

Signature of Responsible Party Today's Date

I authorize my counselor to release information to our billing service: My Client's Plus, for the purposes of billing.

_____ _____

Signature of Responsible Party Today's Date

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

For Office Use Only	
Counselor Assigned:	
Amount due at time of services: $	
Diagnosis 1	Diagnosis 2
Additional Information:	

New Heights Counseling Services, LLC

QUESTIONS TO ASK YOUR INSURANCE COMPANY

Health insurance policies are an agreement between you and your insurance company. To help you understand what coverage you can expect in relationship to outpatient psychotherapy (counseling), simply call your insurance company regarding outpatient behavioral healthcare and ask the following questions. Although not every area of treatment is covered on this form, it should clarify most questions, and be useful in submitting claims.

Date you called your insurance company: _____

Name of the Person who gave you the information:_____

Does my policy cover outpatient psychotherapy? YES NO

Does my policy require pre-certification or pre-authorization? YES NO

If YES, how many visits will be pre-certified? _____

What are the effective dates of the authorization? _____

What is the authorization number? _____

What is the address my provider will use to mail my claim forms? _____

Does my policy require a referral from a doctor within my network? YES NO

Do I have to choose a mental health provider within my network? YES NO

If NO, do I have out-of-network benefits? YES NO

What are my out-of-network benefits? _____

Is (Clinician's Name / Credential) within my network? YES NO

Are there limits to my coverage? YES NO

If YES, what are those limits? _____

Are there limits to the number of visits allowed? YES NO

If YES, how many visits are allowed per year? _____

Is this per calendar year or contract year? _____

What is my deductible? _____ Is that yearly? YES NO Has it been met? YES NO

On what date does the deductible begin? _____

Are there separate deductibles for physical and mental health? YES NO

Do I have a Co-pay or a Co-insurance payment? YES NO

If YES, how much is it or what is the percentage per visit? _____

New Heights Counseling Services, LLC

Couples Counseling Initial Intake Form

Please note that while you will be asked to talk about your answers in sessions, your partner will not be shown this form.

General Information

Your First Name		Your Last Name	
Phone		May I leave a message?	
Relationship Status ☐ Married ☐ Separated ☐ Living Together ☐ Living Apart ☐ Divorced ☐ Dating ☐ Engaged			
Length of time in current relationship	Do you have children together?	Do you have children from a previous relationship?	How many people live in your household?
Partners First Name		Partners Last Name	

Have you ever had previous couples counseling? ☐ Yes ☐ No

If yes, Previous therapist name: _____

What was the outcome (check one)

☐ Very successful ☐ Somewhat successful ☐ Stayed the same ☐ Somewhat worse ☐ Much worse

What do you hope to accomplish through counseling?

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern	**Frequency**
☐ No concern	☐ No occurrence
☐ Little concern	☐ Occurs rarely
☐ Moderate concern	☐ Occurs sometimes
☐ Serious concern	☐ Occurs frequently
☐ Very serious concern	☐ Occurs nearly always

What have you already done to deal with difficulties?

(Continued)

What do you feel are your biggest strengths as a couple?

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 (Extremely Unhappy) 2 3 4 5 6 7 8 9 10 (Extremely Happy)

Have either of you or your partner been in individual counseling before? ☐ Yes ☐ No

If so, give a brief summary of concerns that you addressed?

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 (Extremely Unhappy) 2 3 4 5 6 7 8 9 10 (Extremely Happy)

Have either of you or your partner been in individual counseling before? ☐ Yes ☐ No

If so, give a brief summary of concerns that you addressed?

For the following questions please answer as truthfully and accurately as possible. If there is any information that you do not wish to discuss with your partner please **place a check in the box at the beginning** of the question so we can discuss this in private.

☐ Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No

If yes for either, who, how often and what drugs or alcohol?

☐ Have either you or your partner struck, physically restrained, used violence against or injured the other person? ☐ Yes ☐ No
If yes for either, who, how often and what happened?

☐ Has either of you threatened to separate or divorce (if married) because of the current relationship problems? ☐ Yes ☐ No
If yes, who? ☐ Me ☐ Partner ☐ Both of us

☐ If married, have wither you or your partner consulted with a lawyer about divorce? ☐ Yes ☐ No
If yes, who? ☐ Me ☐ Partner ☐ Both of us

☐ Do you perceive that either you or your partner has withdrawn from the relationship? ☐ Yes ☐ No
If yes, who? ☐ Me ☐ Partner ☐ Both of us

☐ How enjoyable is your sexual relationship? (circle one)

1 (Not Enjoyable) 2 3 4 5 6 7 8 9 10 (Extremely Enjoyable)

☐ How frequently have you had sexual relations with your partner in the last month? _____ times

☐ How satisfied are you with the frequency of your sexual relations? (circle one)

1 (Not Satisfied) 2 3 4 5 6 7 8 9 10 (Extremely Satisfied)

☐ What is your current level of stress overall (circle one)

1 (Not Stressed) 2 3 4 5 6 7 8 9 10 (Extremely Stressed)

☐ What is your current level of stress (in the relationship)? (circle one)

1 (Not Stressed) 2 3 4 5 6 7 8 9 10 (Extremely Stressed)

(Continued)

☐ Check each of the following symptoms you are currently or have experienced within the past 6 months:

Relationship Issues:

☐ Affection
☐ Agreeing on chores
☐ Closeness
☐ Common goals
☐ Common interests
☐ Communication
☐ Finances
☐ Friendships
☐ Relatives
☐ Other: _____

☐ Holding other back
☐ Housing
☐ Infidelity
☐ In-laws
☐ Jealousy
☐ Parenting
☐ Physical fighting
☐ Recreation
☐ Having fun together

☐ Sexual issues
☐ Showing appreciation
☐ Solving problems together
☐ Spouses/partner's cleanliness
☐ Trusting each other
☐ Use of time
☐ Verbal fighting
☐ Guilt / Shame

☐ In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

☐ Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)

☐ Are you currently taking prescribed medications? ☐ Yes ☐ No
If yes, please name the medications and purpose:

Medication	Purpose	Medication	Purpose

☐ Are you currently having any problems with your sleep habits? ☐ Yes ☐ No
If yes are you ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Other

☐ Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No
If yes are you ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

☐ Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

New Heights Counseling Services, LLC

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☐ Housing
☐ Infidelity
☐ In-laws
☐ Jealousy
☐ Parenting
☐ Physical fighting
☐ Recreation
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☐ Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

New Heights Counseling Services, LLC
663 Park Meadow Rd, Suite A
Westerville, OH 43081
614-656-4063

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLREASE REVIEW CAREFULLY

Introduction:

This Notice describes the privacy practices of New Heights Counseling Services, LLC (hereinafter referred to as NHCS). The notice applies to all of the health records that identify you and the care you receive from us. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

Privacy and the Laws:

NHCS is required to give you this Notice of our Privacy Policy because of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPPA). NHCS will follow the terms of this Notice while it is in effect and inform you of any changes. NHCS believes that your health information is personal. It keeps records of the care and services that you receive secured. It is committed to keeping your health information private, and is also required by law to respect your confidentiality.

Who Will Follow This Notice:

Any health care professional authorized to enter information into your clinical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice of Privacy Practices.

Protected Health Information (PHI):

Any information collected regarding your physical or mental health is called Protected Health Information (PHI). This may include the intake assessment, counseling sessions, psychological testing, records requested from other treating professionals and payment for your health care. All of this information comprises your clinical record, which may be stored as paper charts and files, computer and electronic data. The clinical record is the property of NHCS but the PHI in the clinical record belongs to you.

The Use and Disclosure of Protected Health Information:

Use: This is when your information is read by your counselor or other approved NHCS personnel for routine purposes (for example: insurance billing).
Disclosure: This is when your information is shared with or sent to, others outside NHCS.
Consent Form: By law, NHCS may not treat you, unless you give it written authorization to use your PHI for the purposes of treatment, payment and healthcare operations. NHCS may use and disclose this information without your specific consent.
Treatment: NHCS may use and disclose your PHI to provide coordinate or manage your health care and related services. For example, if NHCS consults with other health care providers regarding your

treatment, or if NHCS refers you to another professional such as a physician or psychiatrist, for additional services.
Payment: NHCS may use and disclose your PHI to bill you, your insurance provider or others, to be paid for the treatment provided to you. NHCS may contact your insurance company to check exactly what your insurance covers. They may request information from NHCS, such as dates of services, your diagnoses, treatment received and planned, and progress made. NHCS may also disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us.
Health Care Operations: NHCS may use and disclose your PHI for health care operations to ensure that you receive quality care. For example, to review my treatment and services and to evaluate the performance as it relates to your care.

Appointment Reminders, Test Results and Treatment Information:

NHCS may contact you to provide appointment reminders, test results, or to give you information about other treatments or health-related services that may be of interest to you. Ways NHCS may contact you include voice mail messages, letters, e-mail, text, and other forms of communications, unless you direct it otherwise in writing.

Other Uses And Disclosures Not Requiring Consent or Authorization:

The law requires NHCS to use and disclose some of your PHI without your consent or authorization.
When required by law: There are some federal, state, or local laws, which require it to disclose PHI. By law NHCS is required to report:

- Suspected Child, Elder, or Dependant Person Abuse
- Incidents of Domestic Violence

If you are involved in a lawsuit or legal proceeding and NHCS receives a subpoena, discovery request, or other lawful process, NHCS may have to release some of your PHI. It will only do so after attempting to inform you of the request, consulting your lawyer or trying to get a court order to protect the information requested. NHCS has to release information to the government agencies, which check on us to see that NHCS is obeying the privacy laws.
For Law Enforcement Purposes: NHCS may release PHI if asked to do so by a law enforcement official to investigate a crime or criminal.
For Public Health Activities: NHCS may disclose PHI to agencies, which investigate for the purposes related to preventing or controlling disease, injury or disability.
Related to Decedents: NHCS may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye or tissue donations or transplants.
For Specific Government Functions: NHCS may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to workers compensation programs, to correctional facilities if you are an inmate, and for national security reasons.
To Prevent a Serious Threat to Health or Safety: If NHCS believes that there is a serious threat to your health or safety, or that of another person, or the public, NHCS can disclose some of your PHI. NHCS will only do this to persons who can prevent the danger.

Uses and Disclosures to Which You Have an Opportunity to Object:

NHCS may share your PHI with your family or others involved in your care, such as close friends or clergy. You may inform NHCS as to whom you wish it to contact and the limits of what it may share. NHCS will honor your wishes as long as your request is not against the law. In an emergency NHCS may share information if it believes it is what you would have wanted and is in your best interest. NHCS will tell you, as soon as possible, of the action it has taken. NHCS will discontinue such action at your request as long as it is not against the law.

Your Personal Health Information Rights:

Rights to Request Restrictions: You may submit a written request indicating the PHI you wish to restrict or limit being disclosed. NHCS is not required to agree with your request.
Right to an Accounting of Disclosures: When NHCS discloses your PHI it keeps records to who it was sent, when, and what was sent. You may submit a written request for a list of these disclosures. You must state the time period of disclosures you are requesting that is no longer than 6 years.
Right to Amend: You may request in writing an amendment to your PHI that is incorrect or incomplete indicating a reason that supports your request. If NHCS denies your request you have the right to file a statement of disagreement with DMH. Such statements and our rebuttal will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.
Right to Inspect and Copy: You may make a written request to inspect and copy your PHI. NHCS may deny your request in limited circumstances, including psychotherapy notes, information for use in civil, criminal and administrative action and PHI to which access is prohibited by law. If NHCS denies access you may request the denial to be reviewed by another licensed health professional. NHCS reserves the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.
Right to Request Confidential Communication: You may specify, in writing, how or where you wish to be contacted to NHCS regarding the confidential communication of your PHI. You do not need to give us a reason for such a request. NHCS will accommodate all reasonable requests, but reserve the right to deny those that impose an unreasonable burden on the practice.
Right to a Paper Copy of this Notice: If you have agreed to receive this Notice of our Privacy Practices electronically, you may request a paper copy.

Uses and Disclosures Which You Authorize:

Other than as stated above, NHCS will not disclose your PHI, other than with your written authorization. You may revoke your authorization, in writing, at any time, except to the extent that NHCS has already taken action upon the authorization previously submitted.

IF YOU HAVE QUESTIONS OR PROBLEMS:

If you need more information or have questions about the privacy practices described in this document, please speak to David Hite whose telephone number is at the beginning of the document. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated contact DMH. You have the right to file a complaint with DMH and with the Secretary of the Federal Department of Health and Human Services. NHCS promises that it will not in any way limit your care here or take any actions against you in you complain.

U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
Phone: 312-886-2359

Office of Civil Rights
Department of Health and Human Services
Mail Stop Room 506F
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Phone: 202-205-8725