

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 <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, which number above <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work				
Date of Birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
Soc. Sec. Num.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, which number above <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work				
Date of Birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
Soc. Sec. Num.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other			
Employer Name		School Name (If Student)		

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Primary Insurance Information				
(You must complete this section and present a copy of your insurance card 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 State	Subscriber Zip
Subscriber Home Phone	Subscriber Work Phone		Subscriber Date of Birth	
Subscriber Soc. Sec. Num.		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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? _____

NHCS PERSONAL INFORMATION QUESTIONNAIRE - ADULTS

*This information will be kept confidential and is intended to assist us in helping you.
Please answer all questions as accurately as possible. If you have any questions, please ask.*

NAME _____ DATE _____

WHAT ARE YOU SEEKING HELP WITH? _____

- DO YOU HAVE ANY PROBLEMS WITH YOUR "NERVES?" YES NO
- HAS ANYTHING BEEN WORRYING OR BOTHERING YOU? YES NO
- DO YOU HAVE ANY PROBLEMS WITH "DEPRESSION?" YES NO
- WITH YOUR TEMPER, DO YOU HAVE A, SHORT FUSE MEDIUM FUSE LONG FUSE
- DO YOU HAVE ANY PROBLEMS WITH YOUR THINKING OR MEMORY? YES NO (SLUMS, R4C2)
- HAVE YOU EVER SEEN A COUNSELOR OR OTHER MENTAL HEALTH WORKER? YES NO
- HAVE YOU EVER HAD A "NERVOUS BREAKDOWN"? YES NO DON'T KNOW
- HAVE YOU EVER EXPERIENCED A TRAUMATIC EVENT? YES NO DON'T KNOW (ACE, R4C2)
- WERE YOU EVER HOSPITALIZED FOR YOUR NERVES OR EMOTIONAL PROBLEMS? YES NO
- DOES ANYONE IN YOUR FAMILY HAVE NERVE PROBLEMS? YES NO DON'T KNOW
- HAVE YOU HAD ANY SUICIDAL THOUGHTS OR ATTEMPTS? YES NO (SBQ-R, R4C2) R1C2

BACKGROUND INFORMATION

- ARE YOU MARRIED OR IN ANOTHER LONG-TERM RELATIONSHIP? YES NO
- IF SO, IS YOUR MARRIAGE/RELATIONSHIP, GOOD FAIR POOR
- DO YOU HAVE CHILDREN? YES NO
- IF SO, IS YOUR RELATIONSHIP WITH YOUR CHILDREN, GOOD FAIR POOR
- WHAT OTHER FAMILY DO YOU HAVE CONTACT WITH? MOTHER FATHER SISTER(S)
- BROTHER(S) GRANDFATHER(S) GRANDMOTHER(S) IN-LAW(S)
- MY CURRENT HOUSING IS: GOOD FAIR POOR VERY POOR
- DO YOU HAVE ENOUGH MONEY TO LIVE ON? YES SO-SO NO
- ARE YOU ABLE TO KEEP UP WITH YOUR CHORES/RESPONSIBILITIES? YES SO-SO NO
- DO YOU OWN OR HAVE USE OF A CAR? YES NO DO YOU HAVE ANY PETS? YES NO
- ANY CURRENT HOBBIES OR INTERESTS? NO YES (WHAT? _____) R1C5

BACKGROUND

- WERE THERE ANY DIFFICULTIES WITH YOUR BIRTH? YES NO DON'T KNOW
- WHAT IS (OR WAS) YOUR FATHER LIKE? _____
- HOW DO (OR DID) YOU AND YOUR FATHER GET ALONG? GOOD SO-SO BAD
- WHAT IS (OR WAS) YOUR MOTHER LIKE? _____
- HOW DO (OR DID) YOU AND YOUR MOTHER GET ALONG? GOOD SO-SO BAD R1C3/C5

HOW DO (OR DID) YOUR PARENTS GET ALONG? GOOD SO-SO BAD

DO YOU HAVE ANY BROTHERS OR SISTERS? YES NO

HOW DO (OR DID) YOU AND YOUR BROTHERS/SISTERS GET ALONG? GOOD SO-SO BAD

HOW WAS YOUR CHILDHOOD OVERALL? GOOD SO-SO BAD CAN'T REMEMBER MUCH

WERE YOU EVER ABUSED AS A CHILD? YES NO DON'T KNOW (ACE, R4C2)

HOW WAS YOUR HEALTH AS A CHILD? GOOD SO-SO POOR

DID YOU HAVE ANY CHILDHOOD HABITS? SLEEPWALKING NAILBITING NIGHTMARES
 TEMPER TANTRUMS THUMBSUCKING RUNNING AWAY BEDWETTING FEARS

WAS YOUR CHILDHOOD SOCIAL ACTIVITY, TOO LITTLE ABOUT RIGHT TOO MUCH

DID YOU GET INTO ANY TROUBLE AS A CHILD? YES NO R1C3/C5

EDUCATION

HIGHEST GRADE YOU COMPLETED? LESS THAN 12TH GRADE HIGH SCHOOL COLLEGE

ARE YOU CURRENTLY IN SCHOOL? NO YES (WHERE? _____)

DID YOU RECEIVE ANY AWARDS OR HONORS WHILE IN SCHOOL? YES NO

WHAT KIND OF GRADES DID YOU GET? ABOVE AVERAGE AVERAGE BELOW AVERAGE

WERE YOU IN SPORTS, BAND, CLUBS, ETC. WHEN YOU WERE IN SCHOOL? YES NO

IF "YES," WHAT WERE THESE? _____

DID YOU HAVE ANY PROBLEMS WITH LEARNING? YES NO

HOW DID YOU GET ALONG WITH YOUR CLASSMATES? GOOD SO-SO POOR

HOW DID YOU GET ALONG WITH YOUR TEACHERS? GOOD SO-SO POOR R1C5

MILITARY HISTORY: WERE YOU EVER IN THE MILITARY? YES NO (Skip this section)

WHAT BRANCH? _____ WHAT WAS YOUR MOS/JOB? _____

WHERE WERE YOU STATIONED? _____ DATES OF SERVICE? _____

WHAT DO YOU REMEMBER MOST ABOUT YOUR SERVICE? _____

R1C5

WORK HISTORY (Complete all that apply)

ARE YOU WORKING NOW? NO YES, AS A _____

HOW LONG HAVE YOU BEEN AT THIS JOB? _____

HOW DO YOU LIKE YOUR JOB? ENJOY IT TOLERATE IT DISLIKE/HATE IT

DO YOU HAVE ANY SPECIAL JOB SKILLS? NO YES (WHAT? _____)

HOW DO YOU USUALLY GET ALONG WITH YOUR BOSS/SUPERVISOR? GOOD FAIR POOR

HOW DO YOU USUALLY GET ALONG WITH YOUR CO-WORKERS? GOOD FAIR POOR

ANY ACCIDENTS ON THE JOB? YES NO PROBLEMS WITH BEING ABSENT? YES NO

WERE YOU EVER FIRED FROM A JOB? YES NO

PREVIOUS JOBS HELD	HOW LONG ON THAT JOB?
1. _____	_____
2. _____	_____
3. _____	_____

R1C5

SOCIAL HISTORY

DO YOU HAVE ANYONE YOU CAN TALK TO ABOUT YOUR CONCERNS? YES NO

IS YOUR CURRENT SOCIAL ACTIVITY, TOO LITTLE ABOUT RIGHT TOO MUCH

HOW DO YOU USUALLY GET ALONG WITH OTHER PEOPLE? GOOD FAIR POOR

IS THERE ANYONE YOU WOULD LIKE TO SEE MORE OFTEN? YES NO

R1C3

SPIRITUAL/RELIGIOUS INVOLVEMENT (S/R LEVEL 1, R4C4)

AT THE PRESENT TIME, WHAT IS YOUR SPIRITUAL OR RELIGIOUS PREFERENCE? (CHECK ALL THAT APPLY.)

Christian (specify _____) Jewish Hindu Buddhist

Muslim Other (specify: _____) Atheist Uncertain/agnostic

WERE YOU RAISED IN A SPIRITUAL OR RELIGIOUS TRADITION? NO YES

HOW MUCH IS SPIRITUALITY/RELIGION A STRENGTH OR COMFORT TO YOU? NONE A LITTLE A LOT

HAVE YOU EVER HAD A LIFE-CHANGING RELIGIOUS OR SPIRITUAL EXPERIENCE? NO YES

IN YOUR COUNSELING, ARE YOU OPEN TO EXPLORING HOW YOUR SPIRITUALITY OR RELIGION MIGHT HELP YOU IN DEALING WITH YOUR PRESENTING CONCERN(S)? YES NO I'M NOT SURE

R1C4

CURRENT HEALTH

HOW IS YOUR HEALTH NOW? VERY GOOD GOOD FAIR POOR VERY POOR

WHAT ARE YOUR MAIN HEALTH CONCERNS? _____

WHO IS YOUR FAMILY DOCTOR? _____

WHEN DID YOU LAST SEE A DOCTOR? _____ WEEKS/MONTHS/YEARS AGO (CIRCLE ONE)

WHAT MEDICINES DO YOU TAKE? _____

HAVE YOU EVER TAKEN TRANQUILIZERS OR "NERVE PILLS"? YES NO

HAVE YOU EVER HAD A PROBLEM WITH MEDICINES? YES NO IF YES, WHAT? _____

HAVE YOU EVER USED ANY OF THE FOLLOWING (CHECK ALL THAT APPLY);

AMPHETAMINES/SPEED COCAINE/CRACK MARIJUANA PCP, ANGEL DUST

HALLUCINOGENS (LSD, MAGIC MUSHROOMS) HEROIN, CODEINE, MORPHINE

INHALANTS (GAS, GLUE, PAINT THINNERS) CLUB DRUGS (LIKE ECSTASY) TOBACCO

DO YOU DRINK ALCOHOL? NO YES (If "Yes," please answer the following; **CAGE, R4C2**)

Have you ever tried to cut down on your drinking? NO YES

Have people annoyed you by criticizing your drinking? NO YES

Have you ever felt bad or guilty about your drinking? NO YES

Have you ever had a drink first thing in the morning to settle your nerves or to get rid of a hangover?

NO YES

DO YOU HAVE ANY SEXUAL CONCERNS? YES NO DON'T KNOW

HAVE YOU EVER HAD ANY CONTACT WITH THE POLICE OR LEGAL SYSTEM? YES NO

IF "YES," PLEASE EXPLAIN _____

R1C1

CURRENT AREAS OF CONCERN - ADULTS (DSM-5 Level 1, R4C2)

Instructions: The questions below ask about things that might have bothered you. For each question, **circle the number** that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality overall?	0	1	2	3	4	
IX.	15. Problems with memory (learning new information) or with location (finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN , (without a doctor's prescription) in greater amounts or longer than prescribed: painkillers, stimulants (e.g., Ritalin), sedatives/tranquilizers (e.g., sleeping pills, Valium)	0	1	2	3	4	

THANK YOU FOR PROVIDING THIS IMPORTANT INFORMATION.

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST OR TO YOUR THERAPIST.

Revised, 7/12/16

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 PLEASE 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
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