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
Child/Adolescent Intake Form

First Appointment: ____________________________ Today's Date: ____________________________

Child Information

Form being completed by ☐ Parent ☐ Foster Parent ☐ Guardian ☐ Other: ______________________

Childs Last Name	Childs First Name	Childs Initial

Date of Birth	Sex ☐ Male ☐ Female ☐ Other

Name of Current School	Current Grade

Referred by: ☐ Internet ☐ Pediatrician ☐ School ☐ Social Services ☐ Other: ____________________

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

Emergency Contact Person:

Relationship	Phone

Legal Custodian 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	Relationship to Child

New Heights Counseling Services
Child/Adolescent Intake Form

Child History Questionnaire
Child's main problem/major reason for seeking help at this current time:
How long has your child had these problems, symptoms, or issues?
Has your child had counseling for these issues in the past? ☐ Yes ☐ No
If YES, was the outcome helpful? ☐ Yes ☐ No
Has your child had inpatient mental health treatment? ☐ Yes ☐ No
If YES, briefly list the date(s), name of facility/therapist, presenting issues and outcome:
Describe any other behavioral or emotional problems your child is having:
Describe your child's strengths and unique qualities:
Is your child currently under the care of a physician or psychiatrist? ☐ Yes ☐ No
If YES, Doctor's Name: Phone #

New Heights Counseling Services
Child/Adolescent Intake Form

Is your child currently taking any medications? ☐ Yes ☐ No

Name of Medication	Prescribed By	Prescribed For

Does this child have a history of abuse (physical, sexual, emotional, neglect)? ☐ Yes ☐ No

If YES, please describe briefly, including date(s), location, perpetrator(s), type of abuse and impact on the child and family:

Is there legal action pending related to accusations of abuse? ☐ Yes ☐ No

If YES, describe briefly:

Is there any other legal action that may have impacted your child? Please check all that apply below:

	Current	Past		Current	Past
Custody	☐	☐	Visitation	☐	☐
Adoption	☐	☐	Child Protective Services	☐	☐
Probation	☐	☐	Other	☐	☐

Describe briefly:

New Heights Counseling Services

Child/Adolescent Intake Form

Behavior Checklist Please check any of the following behaviors that concern you:					
Behavior	**Current**	**Past**	**Behavior**	**Current**	**Past**
Crying, sadness, depression	☐	☐	Temper outbursts	☐	☐
Loss of enjoyment of usual activities	☐	☐	Irritability, anger	☐	☐
Expressing a wish to die	☐	☐	Argues a lot	☐	☐
Bedtime fears, won't sleep	☐	☐	Disobedience	☐	☐
Has threatened/attempted suicide	☐	☐	Does things that annoy others	☐	☐
Worries more than others	☐	☐	Unusual fears or phobias	☐	☐
Panics	☐	☐	Anxious, nervous	☐	☐
Repeats unnecessary act over and over	☐	☐	Is overly concerned about things	☐	☐
Has rituals, habits, superstitions	☐	☐	Twitches or unusual movements	☐	☐
Eats very little/fasts to lose weight	☐	☐	Gorges or binge eats	☐	☐
Sleepwalking	☐	☐	Blames other for own mistakes	☐	☐
Withdrawn	☐	☐	Easily annoyed by others	☐	☐
Nightmares, night tremors	☐	☐	Swears or uses obscene language	☐	☐
Low self-esteem	☐	☐	Wanting to run away	☐	☐
Wakes up very early, unable to go back to sleep	☐	☐	Sneaks out at night	☐	☐
Tiredness, fatigue	☐	☐	Injures self	☐	☐
Restless sleep, wakes frequently	☐	☐	Stealing	☐	☐
Trouble going to sleep	☐	☐	Lying	☐	☐
Sleeps too much	☐	☐	Hurts animals	☐	☐
Poor appetite	☐	☐	Destroys property	☐	☐
Under or overweight	☐	☐	Hurts people	☐	☐
Over-activity	☐	☐	Drug Use	☐	☐
Frequently acts without thinking	☐	☐	Alcohol use	☐	☐
Doesn't finish things	☐	☐	Cigarette use	☐	☐
Disruptive	☐	☐	Sexual problems	☐	☐
Short attention span	☐	☐	Problems with authority	☐	☐
Daydreams, fantasizes	☐	☐	Problems with law enforcement	☐	☐
Easily distracted	☐	☐	Low motivation	☐	☐
Hallucinations	☐	☐	Vomits intentionally	☐	☐
Bedwetting/daytime wetting	☐	☐	Soiling (pooping) in pants	☐	☐
Strange or unusual behavior	☐	☐	Disorientation	☐	☐
Pornography	☐	☐	Masturbation/Sexual Activity	☐	☐

New Heights Counseling Services
Child/Adolescent Intake Form

Forms of discipline used in the home: ☐ Time out ☐ Loss of privileges ☐ Grounding
☐ Rewards/incentives ☐ Extra Chores ☐ Physical/corporal punishment ☐ Spanking
☐ Other:

Relationship Development
Check each item that describes your child:

	Current	Past		Current	Past
Prefers to be alone	☐	☐	Is demanding and bossy	☐	☐
Is alone a lot, but dislikes this and feels lonely	☐	☐	Fights with others	☐	☐
Is shy	☐	☐	Bullies others	☐	☐
Has few friends	☐	☐	Teases a lot	☐	☐
Has many friends	☐	☐	Plays with younger kids	☐	☐
Plays with "problem kids"	☐	☐	Poor with older kids	☐	☐
Is picked on a lot	☐	☐	Poor relationships with peers	☐	☐
Is oversensitive	☐	☐	Conflict with parents/step-parents	☐	☐
Poor relationship with teachers	☐	☐	Has difficulty getting along with brothers and sisters	☐	☐

School
Check any area of concern:

	Current	Past		Current	Past
Dislikes school	☐	☐	Missed many school days	☐	☐
Works hard but does not do well	☐	☐	Repeated a grade	☐	☐
Unmotivated, refuses to complete work	☐	☐	Discipline referrals, detentions	☐	☐
Learning problems	☐	☐	Suspensions	☐	☐
Expulsions	☐	☐			

If your child has been suspended or expelled, please explain below:

New Heights Counseling Services
Child/Adolescent Intake Form

Family Stressors Check all that apply:					
	Current	**Past**		**Current**	**Past**
Marital problems	☐	☐	Housing problems	☐	☐
Marital separation	☐	☐	Legal issues	☐	☐
Divorce	☐	☐	Death of a friend	☐	☐
Custody disputes	☐	☐	Death of a relative	☐	☐
Financial problems	☐	☐	Death of a pet	☐	☐
Job loss	☐	☐	Family illness	☐	☐
Parents using alcohol/drugs	☐	☐	Other stressors	☐	☐

If other stressors, please describe:

Developmental History

During pregnancy, did mother: ☐ Drink alcohol ☐ Use drugs ☐ Illness ☐ Accident

☐ Problems with pregnancy ☐ Problems with labor ☐ Problems with delivery

If any checked, please describe:

Please check if child is/was delayed in any of the following areas: ☐ Holding head up ☐ Turning over

☐ Sitting up ☐ Crawling ☐ Walking alone ☐ Weaning ☐ Feeding self ☐ Toilet training

☐ Using single words ☐ Using sentences ☐ dressing self ☐ sleeping through night

Briefly explain any delays:

New Heights Counseling Services
Child/Adolescent Intake Form

As a baby/toddler was the child: ☐ Eating well ☐ Colicky ☐ Head banging ☐ Clumsy

☐ Performing rocking behavior ☐ Easy to regulate (sleeping/eating) ☐ Wanting to be left alone

☐ Easy to soothe ☐ Performing risky and or daredevil behavior

Child Medical History

Condition	Yes	No	Age	Details
Serious infection	☐	☐		
Convulsions/seizures	☐	☐		
Head injuries	☐	☐		
Other injuries	☐	☐		
Hospitalizations	☐	☐		
Surgeries	☐	☐		
Ear infections	☐	☐		
Poisonings	☐	☐		
Allergies	☐	☐		
Asthma	☐	☐		
Alcoholism	☐	☐		
Drug use	☐	☐		
Sexual problems	☐	☐		

Does your child have any other medical conditions? ☐ Yes ☐ No

If YES, please describe:

Does your child frequently complain of bodily aches and pains? ☐ Yes ☐ No

If YES, please describe:

New Heights Counseling Services
Child/Adolescent Intake Form

Does your child miss school because of his/her physical complaints? ☐ Yes ☐ No
If YES, please describe:
Does your child have any allergies to medications, drugs or foods? ☐ Yes ☐ No
If YES, please describe:

Family History List all of the people who currently live with the child			
Name	**Age**	**Relationship**	**Occupation/School and Grade**

New Heights Counseling Services
Child/Adolescent Intake Form

Indicate if any family members or relatives have the following:

	Mother		Father		Brother		Sister		Other	
Problem	Now	Past	Now	Past	Now	Past	Now	Past	Now	Past
Problems with attention, activity or impulse control as a child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning disabilities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Did not graduate from high school	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problems with aggressive behavior as adult or child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Antisocial behavior (arrests, jail, legal problems, probation, other)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abuse victim	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abusive to others	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nervous disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Serious illness or surgeries	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical handicaps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tics or unusual movements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other mental problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

What are your family supports? (church, friends, clubs, etc.) ____

____

____

What are your family strengths? ____

____

____

Please list any adult(s) who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian are unavailable:

Name	**Relationship to Child**	**Phone #**

New Heights Counseling Services
Child/Adolescent Intake Form

I, ______________________________________ (Name of Parent or Guardian) give my permission

to ______________________________________ (Name of Counselor), to see my son or daughter,

______________________________________ (Name of Minor Child), for counseling services with or without my being present during sessions. I/We understand that we have the right to control the disclosure of private behavioral health information about my child. However, in the interest of resolving the issues, I/We have brought to the counselor, I/We give the counselor permission to reveal or withhold information to/from us or others that in the counselor's judgement is necessary to best help and protect my/our children.

____ ____________________
Name of Guardian (Print) Date

____ ____________________
Signature of Guardian Date

____ ____________________
Name of Counselor (Print) Date

____ ____________________
Signature of Counselor Date

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