CAHABA COUNSELING

Client Information Form – Nikki O'Dell, MSW, LICSW

Today's Date _____ Cell Phone _____
Work Phone _____

Client's Name_____
Address _____City _____State _____Zip _____
E-mail_____
Age _____ Date of Birth _____
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Employer-Self_____ Occupation_____
Employer-Spouse_____ Occupation_____

Why are you seeking counseling for yourself or your child?_____
_____
_____
Are you currently in counseling elsewhere? ❑ Yes ❑ No

How were you referred to our office? ❑ FBCT website ❑ Psychology Today
❑ Word of Mouth ❑ Provider Referral _____ ❑ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name_____ Relationship to Client_____
Address _____

City _____ ST _____ Zip _____
Date of Birth _____ E-mail _____
Cell Phone _____ Alternate Phone _____

I understand that a card will be kept on file when I schedule an appointment and that card will be charged after each session. _____ (Initial)

REQUIRED INFORMATION

Credit/Debit/HSA Card Number you wish to use for payment/copay:

_____

Expiration Date:_____ CVV Code: _____

Zip Code Associated with this card: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Phone Number: _____

Co-pay amount: _____ Deductible: _____

Is your deductible met?_____ I understand if my deductible is not yet met, I am responsible for the session fee of $110. _____(Initial)

Insurance ID number: _____Group Number: _____

Subscriber's Name: _____

DOB: _____ SSN: _____City: _____

State: _____ Zip Code: _____

Relationship to client: _____

CLIENT EMAIL/TEXTING INFORMED CONSENT

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by therapist's intentional misconduct. Client/Parent/Legal Guardian must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email/text will be read and responded to within any particular period of time.
b. Email and texts should be concise. The client/parent/legal guardian should call and schedule an appointment to discuss complex or sensitive situations.
c. Client/Parents/Legal Guardians should not use email or texts for communication of sensitive medical information.
d. Provider is not liable for breeches of confidentiality caused by the client or any third party.

e. It is the client/parent/legal guardians responsibility to follow up and schedule an appointment if it's warranted.

Client Name: _____

Client Signature:_____ Date:_____

Parent/Legal Guardian Signature: _____ Date: _____

ABOUT YOUR HEALTH

Primary care physician: _____

Any concerns shared by the doctor? _____

Describe any allergies you have: _____

Do you have any chronic medical concerns? ❑ Yes ❑ No
If so, please list:

_____

_____

Do you have a mental health diagnosis? ❑ Yes ❑ No
If so, please list:

_____

_____

Are you under the care of a psychiatrist? _____ If so, whom? _____

Have you been prescribed any psychotropic drugs by your psychiatrist? ❑ Yes ❑ No
List all medications or drugs (legal or illegal) you have taken in the last year:

_____

List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had.

_____

_____

_____

Emergency Contact

Name: _____ Relationship: _____

Phone number: _____

Professional Disclosure Statement and Informed Consent

PLEASE INITIAL EACH ITEM:

_____ I understand that Nikki O'Dell, LICSW does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 911 or go to an emergency room for assistance.

_____ I understand that during the time that we work together, we will meet together bi-weekly or monthly. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

_____ I also understand our contact will be limited to counseling sessions except, only in case of emergency.

_____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

_____ I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes can be temporarily distressing.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Nikki O'Dell, LICSW will not initiate the greetings.

_____ Should I believe that a referral is needed, Nikki O'Dell, LICSW will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that conducting expert witness and testimonial services is not an area of interest of Nikki O'Dell, LICSW and should I subpoena Nikki O'Dell, LICSW as a factual case witness or involve her in any court-related processes, Nikki O'Dell, LICSW charges a retainer fee of $1000.00, with an additional $130.00 every hour she is involved in legal depositions, case preparation, travel, and witness time.

_____ I understand that if I do issue Nikki O'Dell, LICSW a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Nikki O'Dell, LICSW. Client records are disposed of seven (7) years after the client has stopped receiving services

Charges and Cancellations:

PLEASE INITIAL EACH ITEM:

_____ I understand that the rate for individual counseling sessions is $110.00 for a 1-hour session.
_____ I understand that all fees for counseling are due at each session.
_____ I understand that if I do not cancel my appointment at least 48 hours ahead, that spot will not be filled, so I will be charged a $70.00 late cancellation fee.
_____ I understand that if I do not show up for an appointment, it will result in my being charged the full fee ($110) for that missed session.
_____ I understand that if I need to reschedule or cancel a session, I need to contact my therapist directly at 618-406-6640

Limits to Confidentiality:

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- Nikki O'Dell, LICSW is ordered by a court to disclose information.
- You direct Nikki O'Dell, LICSW in writing to release your records.
- Nikki O'Dell, LICSW is otherwise required by law to disclose information.

MENTAL STATUS INFORMATION

Have you, your spouse/significant other or child ever attempted suicide or harmed yourself in any way? ❑ Yes ❑ No

Are you, your spouse/significant other or child, currently thinking about suicide or harming yourself in any way? ❑ Yes ❑ No

Have you, your spouse/significant other or child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ❑ Yes ❑ No

Are you, your spouse/significant other or child having any thoughts about harming anyone else in any way? ❑ Yes ❑ No

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

_____

Client Signature Date

AGREEMENT FOR THERAPY

I,_____

❑ Agree to receive therapeutic services provided by Nikki O'Dell, MSW, LICSW

❑ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.

❑ Furthermore, I understand that I am expected to be an active participant in this process.

❑ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

❑ My signature below means that I understand and agree with all the points above.

_____

Client Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to ensure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPPA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other his use required by law.

Treatment:
We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with This practice, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the

following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office.

_____

Client Signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Nikki O'Dell, MSW, LICSW to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____

Client Signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke This consent in writing, except to the extent that This office has previously taken action in reliance on This consent. Your treatment by This office is conditional on your signing This consent