CHRISTINE DIEVENDORF WEISS, PLLC
5400 Holiday Terrace, Suite 200A Kalamazoo, MI 49009
Phone (269) 520-0050 Fax (269) 520-0051
Email: christine@cweisscounseling.com
Web: www.christineweisscounseling.com

Today's Date:________________________

PERSONAL INFORMATION

Client Legal Name: ___________________________________
DOB:________________________
Preferred Name (if different):__________________________
Gender on Legal/Insurance Records:____________________
Gender Identity/Pronouns (if different):_________________

Phone: ________________________ Text OK? □ Yes □ No
E-Mail: ____

Address: ____
City: ____
State:___________________ **Zip:** ______________________

Alternate Phone: _____________________________________

If we need to reach you, may we leave/send you a message?
Primary Phone: □ Yes □ No
Alternate Phone: □ Yes □ No
Email: □ Yes □ No
Any specific instructions: ______________________________
____

Employment Status:
□ Employed □ Unemployed □ Disabled
□ Retired □ Student

EMERGENCY CONTACT

Relative or friend to contact in case of an emergency:
____

Relationship to Client: ________________________________
Phone: ____

REFERRAL INFORMATION

Whom may we thank for referring you:

□ Self-Referred □ Primary Care Physician □ School
□ Psychiatrist □ Friend □ Relative
□ Web/Social Media
□ Other: ____

INSURANCE/PAYMENT

<u>**Primary Insurance**</u>
Policy Holder's Name: ______________________________
Relationship to Client: ______________________________
Policy Holder's DOB: _______________________________
Policy Holder's Gender: _____________________________
Policy Holder's Home Address (if different):
____
Insurance Company: ________________________________
Insurance Company Phone: ___________________________
Policy Holder's ID#: ________________________________
Group #: ____
Employer Name: _____________________________________

□ **EAP Services**:______________________________________

Financially Responsible Party (If client is a minor, the FRP is usually the parent/guardian authorizing the services)**:**
Name: ____
SSN: ____
Address: ____
City: ____
State:___________________ **Zip:** ______________________
Phone: ____
E-Mail: ____

□ **I prefer to pay directly/out-of-pocket for services and will not be using insurance. I will discuss my payment preferences and rates with my clinician.**

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1. **APPOINTMENTS**: Each appointment is approximately 45-60 minutes in duration, most often 60 minutes. Frequency, duration, and goals of therapy will be based on the individual, couple, or family's need and discussed during your first few appointments. If you would like to receive appointment reminders. Please choose from the following reminder methods:
   _____ (***please initial)*** Via text message to the following cell phone number(s): ____________________________________
   _____ ***(please initial)*** Via email to the following email address(es): ____
   By signing up for appointment reminders you are waiving your right to keep this information completely private and are requesting that it be handled as you have indicated above.

2. **PAYMENTS AND INSURANCE**: All fees (co-pays, deductibles, document preparation, etc.) are due at the time of service, unless other arrangements are documented in writing. A valid payment card can be stored securely in your electronic account and will be charged following each session for the amount equal to your copay, deductible or payment due. You may change your stored payment method at any time, or you may choose to pay by exact cash or check at the time of service. CDWPLLC will bill your insurance for you; however, it is your responsibility to verify insurance coverage as well as additional fees or amounts owed toward deductible. We do not participate with secondary insurance plans but we will provide you with the documentation necessary to request reimbursement from your secondary insurance company, if applicable. It is the responsibility of the client to provide full payment for services if insurance denies payment. Any balances not paid within 3 months may be subject to collection by a third-party agency. By signing this document, the client authorizes the disclosure of personal information necessary for debt collection.

   Credit/Debit card number: ____
   Expiration date: _______ **CCV:** __________ **Name on card:** ____
   Address on card: ____
   ______***By initialing you authorize this card to be stored and used as a method of payment for co-pays, deductible payments, missed appointments/late cancellations, document preparation, and/or participation in legal/court proceedings.***

3. **CANCELLATIONS**: If an appointment needs to be rescheduled or canceled, a 24-hour notice is required. If such notice is not provided, a fee will be added to your account balance. Payment of this fee is due prior to any further services rendered. Insurance companies do not reimburse for missed appointments, and you will be directly responsible for the cancellation/missed appointment fee.

   ______***By initialing you acknowledge the cancellation/missed appointment policy.***

4. **EMERGENCY PROCEDURES**: If you are experiencing a mental health emergency, please contact Gryphon Place by calling (269) 381-HELP (4357). For a mental health emergency involving Kalamazoo County residents under 18 years of age, you may contact the Mobile Crisis Response team at (269) 373-6000. The National Suicide Prevention Lifeline is available at 1-800-273-TALK (8255). You may also contact 911 or go to your local emergency room.

5. **CONFIDENTIALITY**: Confidentiality is of the utmost importance in clinical care. All information and documentation regarding your services will be handled and stored in accordance with HIPAA guidelines, current laws and APA ethics codes. You may request in writing that this information be shared with any source you deem necessary.

____Yes ____No I authorize benefits to be paid directly to my treatment provider.
____Yes ____No I consent to the use of electronic account usage and communications (email, etc.).
____Yes ____No I have received a copy of the HIPAA Privacy Notice (attached to this packet).
____Yes ____No I authorize the release of any medical information necessary to process my insurance claims.
____Yes ____No I consent to the exchange of treatment information between CDWPLLC and primary care physician.
____Yes ____No I authorize de-identified cross clinician communication for the purposes of consultation/supervision.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

____ Date: ____________________
Client/Responsible Party ***Signature***

____
Client/Responsible Party ***Printed Name***

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MEDICAL INFORMATION

Primary Care Physician (PCP): ________________________

PCP Location: ______________________________________

PCP Phone Number: __________________________________

List any current health concerns: ________________________
____
____

Current Medications, Vitamins and Supplements: _________
____
____
____

List any prior surgeries or major injuries: ________________
____
____

Any family history of:
□ Thyroid Problems □ Diabetes □ Pituitary Problems

MENTAL HEALTH INFORMATION

What brings you in for services now?
____
____
____
____

List any prior counseling/psychological services:
- □ Individual Counseling
- □ Psychological Testing
- □ Couples/Family Counseling
- □ Psychiatric Hospitalization
- □ Prescribed Psychiatric Medication

Providers and Approximate Dates Seen:
____
____
____
____

How would you describe your current concerns?
□ Mild □ Moderate □ Severe □ A Crisis

CURRENT CONCERNS (Please Mark All That Apply)

- □ Excessive crying
- □ Unable to have fun
- □ Decreased energy
- □ Feelings easily hurt
- □ Lacking confidence
- □ Feeling overwhelmed
- □ Difficulty making decisions
- □ Constipation
- □ Diarrhea
- □ Feeling panicky
- □ Feeling grouchy
- □ Excessive worrying
- □ Skin picking, hair pulling, or nail biting
- □ Feeling worthless
- □ Poor appetite
- □ Overeating or binging/purging
- □ Feeling sad
- □ Feeling tense or on edge
- □ Feeling angry
- □ Difficulty concentrating
- □ Trouble sleeping
- □ Can’t sit still or antsy
- □ Acts without thinking
- □ Problems handling money
- □ Nightmares
- □ Flashbacks
- □ Mood swings
- □ Unmotivated, procrastinating
- □ Avoiding things
- □ Parenting concerns
- □ Sexual concerns
- □ Threatens or bullies others
- □ Fast heartbeat
- □ Struggles to make/keep friends
- □ Avoiding going places
- □ Problems with parents
- □ Problems with partner
- □ Fighting and quarreling
- □ Family conflict
- □ Relationship issues
- □ Dislike my body
- □ Restricting eating
- □ Hearing voices
- □ Excessive drinking
- □ Drug use
- □ Legal problems
- □ Excessive exercising
- □ I don’t feel safe at home
- □ Thoughts of hurting others
- □ Self-injurious behaviors
- □ Thoughts of suicide
- □ Issues related to sexuality or gender identity
- □ ____________________

Are there any past mental health concerns that you are no longer experiencing? If so, what concerns, approximately when did you experience them, and for how long? ____

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HOUSEHOLD/FAMILY INFORMATION

NAME	GENDER	AGE	EDUCATION	OCCUPATION
CLIENT (S)				
SPOUSE/PARTNER				
PARENTS (if minor client)				
______ ☐ Biological ☐ Adoptive ☐ Step Parent				
______ ☐ Biological ☐ Adoptive ☐ Step Parent				
______ ☐ Biological ☐ Adoptive ☐ Step Parent				
______ ☐ Biological ☐ Adoptive ☐ Step Parent				
CHILDREN IN THE HOME				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				
______ ☐ Biological ☐ Adopted ☐ Step ☐ Half				

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision to resume in-person services during the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign below, this document will serve as verification of your agreement to comply with the following protocols and represents your official informed consent.

Decision to Meet Face-to-Face
Please note: A resurgence of the pandemic or other health concerns may result in my decision to discontinue in person services and return to telehealth services for everyone's well-being. If you have been attending appointments in person but decide at any time that telehealth services are more appropriate for you, I will respect that decision and we will transition to telehealth as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus. These risks are increased if you use public transit or ridesharing for transportation to and from appointments.

Your Responsibility to Minimize Your Exposure
To obtain services in-person, you agree to take certain precautions which will help keep everyone (you, me, our families, my staff, and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it will result in starting/returning to a telehealth arrangement. In order to proceed with in-person sessions, you are signing this document to demonstrate your agreement to these actions:

- You will only keep your in-person appointment if you are and have been symptom-free for the last 14 days.
- If you have an elevated temperature (100°F or more) or other symptoms of the coronavirus, you agree to cancel the appointment OR proceed using telehealth. If you wish to cancel for this reason, I will not charge you our normal cancellation fee.
- You will wear a mask in accordance with current MIOSHA guidelines for *healthcare facilities*. Note: MIOSHA guidelines for healthcare facilities may be different from those issued for other public places.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have had close contact and/or potential exposure to someone who tests positive for the virus or develops symptoms consistent with coronavirus, you will let me know and we may then decide to utilize telehealth.

I may need to adjust the above precautions as additional local, state, or federal orders or guidelines are released. If that happens, we will discuss any necessary changes.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If this becomes necessary, I will provide only the minimum information necessary for their data collection and will not provide any clinical information regarding our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Your signature below demonstrates your agreement to the above terms and conditions.

______________________________________ ______________________
Client or Legal Guardian SIGNATURE Date

____
PRINT Client Name

Office Safety Precautions in Effect During the Pandemic

- My staff and I have been vaccinated and will wear masks in all common areas of the building.
- Hand sanitizer that contains at least 60% alcohol is readily available.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are cleaned throughout and at the end of each day.

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PAYMENT INFORMATION: If you are using insurance for services, your final costs may vary according to our contracted rates with your insurance company. The original fee schedule is as follows:

Initial Appointment (90791) - $230
60 Minute Session (90837) - $200
45 Minute Session (90834) - $175
45 Minute Family/Couples Counseling (90847) - $200

Participation in Legal/Court Proceedings (Including preparation, travel, and court time) - $400/hour
Medical Records Request/Written Correspondence: $50 per document
Missed Appointment/Late Cancellation: Fee equivalent to cost of scheduled session

Fees for any services including and beyond the above mentioned can be discussed with your provider.

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Effective April 14, 2003

HIPAA & RECIPIENT RIGHTS: A federal act called the Health Insurance Portability and Accountability Act (HIPAA) gives you some additional rights to what you have through state laws. This notice gives you information on these additional rights through HIPAA.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE: We obtain information about you when you receive services through Christine Dievendorf Weiss, PLLC (CDWPLLC). It includes your date of birth, gender of record, Social Security Number and other personal information.

OUR PRIVACY COMMITMENT TO YOU: We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment/services, payment, business operations or when we are required by law to do so. We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.

*Treatment/Services: We may disclose information about you with your written consent to coordinate your services. For example, we may give information to your other healthcare providers.
*Payment: We may also use and disclose information so the care you get can be properly billed and paid for. For example, we will submit bills to your insurance company or other entities.
*Business Operations: We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you receive.
*Exceptions: For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.
*As Required By Law: We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, workers' compensation claims, medical examiner or funeral director if an individual dies, subpoenas or other court orders, communicable disease reporting, review of our activities by government agencies, to avert a serious threat to health or safety, reporting suspected abuse, neglect, or domestic violence, or in other kinds of emergencies. *With Your Permission: If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing also. We cannot take back any uses or disclosures already made with your permission.

CLIENT COPY

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YOUR PRIVACY RIGHTS: You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Privacy Officer at CDWPLLC.

*Your Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your paper or electronic health records. We will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a fee for the cost of copying records.
*Your Right to Amend: You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we will give you a written reason for our denial within 60 days.
*Your Right to a List of Disclosures: You have the right to ask for a list of disclosures or your health information for six years prior to the date you ask, who we shared it with and why. This list will not include the times that information was disclosed for treatment, payment, or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.
*Your Right to Request Restrictions on Our Use or Disclosure of Information: You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to your request if it would affect your care. If you pay for your services out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer unless a law requires us to share that information.
*Your Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.
*Your Right to Choose Someone to Act on Your Behalf: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has this authority and can act for you before we take any action.
*Your Right to Share Health Information: You have both the right and choice for us to share information with your family, close friends, or others involved in your care or share information in a disaster relief situation. We never share psychotherapy notes unless you give us written permission or in response to a complaint filed against the clinician. We never market or share personal information.

CHANGES TO THIS NOTICE:
We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE:
If you have questions or would like more information, you may contact our privacy officer at (269)520-0050. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Department of Health and Human Services. You will not be penalized for filing a complaint.

COMPLAINTS AND COMMUNICATIONS TO US:
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Phone: (269) 520-0050
Fax: (269) 520-0051
Email: christine@cweisscounseling.com

COMPLAINTS TO THE FEDERAL GOVERNMENT:
Office of Civil Rights, Department of Health and Human Services
200 Independence Ave. SW
Washington DC 20201
(877) 696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

COPIES OF THIS NOTICE:
You have the right to receive additional copies of this notice at any time. Please call or write to us to receive an additional copy. This adds to your protections through Recipient Rights.

CLIENT COPY