Client Information

Client Name _____ ID'd Gender M F Birth Date _____
Billing Address_____
_____
Phone _____ Cell Y N S.S.# _____
Responsible Party (for minors)_____ Relationship to Client _____
Client's Employer/School _____
Primary Care Physician _____
Phone _____
By whom were you referred? _____

Primary Insurance Information

Policy Holder Name _____ ID'd Gender M F Birth Date _____
Policy Holder Address_____
_____
Employer _____ Work Phone _____
Employer Address _____
Insurance Company_____
Claim Address _____
_____
Phone _____
Policy Holder's Social Security #_____
Policy # _____ Group # _____
Authorization # _____ for _____ sessions
Medicare # _____ Primary _____ Secondary _____
Are you covered by any other insurance carrier? Yes _____ No _____ If yes, complete next section.

Secondary Insurance Information

Policy Holder Name _____ Id'd Gender M F Birth Date _____
Insurance Company _____
Claim Address _____
_____
Phone _____
Policy Holder's Social Security #_____
Policy # _____ Group # _____

The client's, or responsible person's, signature below indicates: 1) your understanding and agreement that Bethany Dwinnell follows your privacy rights as defined by HIPAA. A copy of the HIPAA statement is available upon request; 2) authorizes release of any information including medical, the dates of service, services rendered and diagnosis requested by the insurer in order to process the claims and payment of mental health benefits to be made; 3) indicates your understanding and agreement that you are responsible for any charges not paid by your insurer or other third party.
Signature _____ Date _____

Client Name: _____ **Date:** _____

Please describe the primary issues for which you are seeking assistance: _____
_____

Please rate the following life areas on a 1 to 5 scale: 1 = no concern to 5 = primary/strong concern

Marital or partner relations	1	2	3	4	5	n/a
Family relations with parents and/or siblings	1	2	3	4	5	n/a
Special family issues (step, blended families, adoption)	1	2	3	4	5	n/a
Other interpersonal relationships (friend, peer, co-worker)	1	2	3	4	5	n/a
General mental and emotional health (e.g. anxiety, depression)	1	2	3	4	5	n/a
Alcohol and/or substance abuse/dependence □ Self □ Other	1	2	3	4	5	n/a
Job/Career concerns	1	2	3	4	5	n/a
School and/or school-related issues	1	2	3	4	5	n/a
Financial and/or legal	1	2	3	4	5	n/a
Concern for physical health	1	2	3	4	5	n/a
Physical, verbal, emotional and/or sexual abuse	1	2	3	4	5	n/a
General lifestyle or life-stage changes	1	2	3	4	5	n/a
Other:_____	1	2	3	4	5	n/a

Please check those items which describe your recent experience or behavior:

____Tremors, ticks, shaking
____Headaches
____Muscle pains
____Nausea/upset stomach
____Stomach pain
____Diarrhea
____Constipation
____Tension in chest
____Dizziness/fainting
____Fatigue
____Increased sweating
____Hives
____Confusion
____Inability to concentrate
____Feeling of anger/rage
____Feeling of sadness
____Desire to cry
____Insomnia
____Increased sleeping
____Sexual functioning problems
____Feeling restless/trapped
____Feeling afraid
____Feeling irritable
____Loss of appetite
____Weight loss
____Overeating
____Weight gain
____Increased smoking
____Increased alcohol/drug
____Other_____

Under the care of a physician? ___ **Name:**_____
Medication(s)/purpose: _____
_____

Rate your overall health: ____Poor ____Fair ____Good ____Excellent

Overall, please rate the degree to which the area(s) of concern has/have affected your life on a 1 to 9 scale:

1 = very little and 9 = great deal 1 2 3 4 5 6 7 8 9

Please check those statements which describe your recent experience or behaviors related to work:

____Received verbal warning(s)
____Received written warning(s)
____Placed on probation
____Suspended
____Had an accident at work
____Conflicts with boss
____Conflicts with co-workers
____Arriving late
____Leaving Early
____Taken sick days
____Used disability
____No problems

Please rate your overall job satisfaction: ____None ____A little ____Moderate ____Very ____Extremely

Practice Policies

Bethany Dwinnell, LISW is a clinical social worker licensed and certified by the State of Ohio. Your first session is designed to provide for problem assessment, crisis intervention (if needed) and the development of an initial treatment plan. Each session typically consists of 45-50 minutes of face-to-face meeting with your therapist.

You are responsible for co-payments or other fees specified for each session. If your insurance company covers part or all of the services, I will bill your company directly. However, if you are required to pay any deductibles or co-payments, you must make these payments at each session. If you make an overpayment I will refund such payments to you.

If your health benefit plan requires prior approval or physician referral for mental health services, **you are required to obtain such approvals/referrals and to present the authorization number at your first visit.**

I have read and agree to the above.
Client/Guardian signature: _____

All information that you provide in sessions (with the exceptions below) will not be disclosed outside of this practice without your signed authorization or consent specifying what information is to be sent and to whom.

Exceptions regarding the confidentiality policy include:

1. Reports of suspected physical abuse, sexual abuse, and/or neglect of children which are required by Ohio law to be reported to a county's child protective agency, e.g. Franklin County Children's Services.
2. Reports of suspected abuse of elderly persons which are required by Ohio law to be reported to the Ohio Department of Human Services.
3. Potential harm, danger or threat of death to oneself or another person in which cases, the practice may advise police and/or intended victims and/or those relations (such as parents) in positions of guardianship.

By Ohio Law, minors may only receive services with the written approval of a custodial parent or legal guardian.

I have read and agree to the above.
Client/Guardian signature: _____

A 24-hour cancellation policy or rescheduling notification is necessary to enable the therapist to schedule other individuals waiting for appointments. If you do not show up for an appointment or fail to cancel with **at least a 48 hour notice, you will be charged $80 for the session.**

I have read and agree to the above.
Client/Guardian signature: _____

Date: _____