Client Information

Client Name _____ ID'd Gender M F Birth Date _____
Billing Address _____
_____
Phone _____ Cell Y N Responsible Party _____
Relationship to Client _____
Client's Employer/School _____
Primary Care Provider _____
By whom were you referred? _____

Primary Insurance Information

Policy Holder Name _____ ID'd Gender M F Birth Date _____
Policy Holder Address _____
_____
Employer _____
Insurance Company _____
Phone _____
Policy # _____ Group # _____
Authorization (when applicable) # _____ for _____ sessions
Medicare # _____ Primary _____ Secondary _____
Are you covered by another insurance carrier? Yes _____ No _____ *If yes, please complete next section.*

Secondary Insurance Information

Policy Holder Name _____ ID'd Gender M F Birth Date _____
Insurance Company _____
Phone _____
Policy # _____ Group # _____
Authorization (when applicable) # _____ for _____ sessions

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 briefly describe the primary issues for which you are seeking assistance:

_____

_____

Please rate the life areas on a 1 to 5 scale: 1 = no concern 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 (anxiety, depression)	1	2	3	4	5	n/a
Alcohol and/or substance abuse/dependence	1	2	3	4	5	n/a
Self Other						
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	____Increased sweating	____Feeling restless/trapped
____Headaches	____Hives	____Feeling afraid
____Muscle pains	____Confusion	____Feeling irritable
____Nausea/upset stomach	____Inability to concentrate	____Loss of appetite
____Stomach pain	____Feeling of anger/rage	____Weight loss
____Diarrhea	____Feeling of sadness	____Overeating
____Constipation	____Desire to cry	____Weight gain
____Tension in chest	____Insomnia	____Increased smoking
____Dizziness/fainting	____Increased sleeping	____Increased alcohol/drug
____Fatigue	____Sexual functioning	____Other_____

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

Under the care of a physician/provider? _____ Name: _____

Medication(s)/purpose: _____

_____

_____

Rate your overall health: ____ Poor ____ Fair ____ Good ____ Excellent

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

____Received verbal warning(s)	____Had an accident at work	____Leaving Early
____Received written warning(s)	____Conflicts with boss	____Taken sick days
____Placed on probation	____Conflicts with co-workers	____Used disability
____Suspended	____Arriving late	____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 two sessions are 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 all 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 copayments, 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 all of 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 all of 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 for an appointment or fail to cancel with at least a 24 hour notice, you will be charged $100 for the session or equal to the reimbursement rate of your insurance company.

I have read and agree to all of the above.

Client/Guardian signature: _____ Date: _____