Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

**220 South Railroad Street, Suite 3**

**Palmyra PA 17078**

**717 644 1868**

**calm@michellebatzcounseling.com**

**General Information**

Client name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 16, please give mother’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and father’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M D W Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current status: ☐ Student ☐ Employed ☐Unemployed ☐ Homemaker ☐Retired ☐Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If student, are you Full Time or Part Time? FT PT Please give the School attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If working, please give Occupation and Place of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternative Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If person filling out form is not client, check here: ☐ What is your relationship to client?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address & Contact information**

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Okay to call Y N Okay to leave a message? Y N

Email *(used for scheduling issues and payment reminders)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any special instructions when calling, leaving messages or emailing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initials and Signatures**

\_\_\_\_\_\_ I understand it is my responsibility to pay for the session at the time of service. It is also my responsibility to pay the full session fee for no-show or cancellations with less than 48 hours notice.

 FEE SCHEDULE (Hourly)

 $130 Office/Telehealth Session

 $100 Case Management

\_\_\_\_\_\_\_I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment. I understand that I am legally obligated to pay any fees not covered by my insurance company, co-pays, or full payments for missed sessions. I understand that I am responsible for finding out the mental health benefits and am responsible for any pre-authorization required by my insurance company.

\_\_\_\_\_\_ I affirm that I have willingly sought treatment from Michelle Batz Counseling for issues relating to the field of mental health. I recognize that such treatment may involve exploration of my personal and family experiences and has the potential to be emotionally unsettling. I agree and consent to receive treatment from my therapist at this time. I understand that I have the right to terminate such treatment at any time.

\_\_\_\_\_\_ I acknowledge that I have received, read, signed and consent to abiding by the Client Rights and Responsibilities document.

\_\_\_\_\_\_I acknowledge that I have read and consent to the Notice of Privacy Practices document, which explains in detail my rights to access my Personal Health Information and how, when and with whom that information may be shared.

\_\_\_\_\_\_I acknowledge that if my therapist deems the treatment I require to be beyond her level of training or resources as a practitioner that it is her/his ethical duty to provide referrals to other professionals or agencies. In the event that such a referral is, in his/her opinion, necessary for treatment to be effective, I recognize that in order to continue in therapy with them I will need to follow up on such referrals and/or obtain additional licensed clinical responsibility for my care. Such situations may include (but are not limited to): recurrent suicidality, alcohol or chemical dependency, eating disorders, domestic violence, symptoms of bipolar, psychosis or a personality disorder.

\_\_\_\_\_\_ I agree that my therapist’s sole responsibility is in working with me as a therapist and that I will not enlist in any legal proceedings related to my case. I further agree that neither he/she or his/her records nor her testimony will be subpoenaed for deposition or court testimony, and she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

Client Name (please print legibly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Both parents are required to sign for consent for services for clients under 18 years old.

*Consent for Eye Movement Desensitization and Reprocessing Treatment*

 EMDR therapy is recognized as an effective form of trauma treatment in numerous practice
guidelines worldwide. In the US, this includes organizations such as the American Psychiatric
Association and Department of Defense. More than twenty randomized studies support the effectiveness
of the therapy in treatment of PTSD.

EMDR is a comprehensive, integrative psychotherapy approach. It contains elements of many
effective psychotherapies in structured protocols that are designed to maximize treatment effects. These
include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies.
EMDR psychotherapy is an information processing therapy and uses an eight phase approach to
address the experiential contributors of a wide range of pathologies. It attends to the past experiences that
have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs
and sensations, and the positive experience needed to enhance further adaptive behaviors and mental
health.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been advised and understand that Eye Movement
Desensitization and Reprocessing (EMDR) is a treatment approach that has been widely validated by
research only with PTSD. Research on other applications of EMDR is now in progress.
I have also been specifically advised of the following:

Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients
have experienced reactions during the treatment sessions that neither they nor the administering clinician
may have anticipated, including a high level of emotion or physical sensations.

Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams,
memories, flashbacks, feelings, etc., may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained
whatever additional input and/or professional advice I deemed necessary or appropriated to having
EMDR therapy, and by my signature below I hereby consent to receiving EMDR treatment. My signature
on this Acknowledgement and consent is free from pressure or influence from any person or entity.

Client Name (please print legibly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

*Intake Form*

*The information requested on this form is intended to be helpful to you and your therapist in the provision of the best possible services to you. If there is any question that you would prefer not to answer, please feel free to leave blank and discuss in session.*

FULL NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name you prefer to be called\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problem**

1. What is/are the reason(s) you are seeking therapy today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Did a specific event lead to this report for services? 󠄀Yes 󠄀No If yes, please describe the incident. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. How long has the problem been present? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What solutions to the problem have you tried, and what were the results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. How much does this problem affect your life? (Please circle the number that best applies)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **A little bit** | **A lot** | **All the time** |
| 1. Personally | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 2. Family Life | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 3. Socially | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 4. Work-wise | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |

7. How were you referred to this service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you make use of community-based support groups (e.g. 12-Step Programs, social support groups, etc)? 󠄀Yes 󠄀No If yes,

please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Do you have an involvement with any of the following people or services? 󠄀Yes 󠄀No If yes, please circle all that apply:

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum Worker’s Compensation

If so, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

10. Please look these items over and circle the number that best describes how these symptoms have bothered you **recently.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Mildly** | **Moderately** | **Severely** |
| 1. Depressed | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 2. Guilty Feelings | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 3. Suicidal thoughts, plans, or attemptsHave you ever thought about, planned or attempted suicide? Thought about: Y N Planned: Y N Attempted: Y N If yes to any of these, when was this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 4. Changed sleep patterns:☐ Difficulty falling asleep ☐ Difficulty staying asleep☐ Can’t get up in a.m. ☐ Nightmares | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 5. Change in weight or eating habits: ☐ Increase ☐ Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 6. History of restrictive eating, dieting or purging | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 7. Insecurity or inferiority | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 8. Loss of interest or energy in pleasurable activities | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 9. Anxious, nervous, or panicky feelings | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 10. Avoiding places or situations | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 11. Repetitive thoughts or behaviors | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 12. Change in work habits: ☐ Increase ☐ Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 13. Change in spending habits: ☐ Increase ☐ Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 14. Anger or temper problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 15. Flashbacks or intrusive memories | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 16. Physical problems, pain, or illness | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 17. Sexual worries or problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 18. Brain fog, fuzzy thinking or dissociation | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 19. Memory problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 20. Confused or disorganized thoughts | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 21. Periods of high energy/activity with less need to sleep | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |

11. Do any of the following concerns contribute to your symptoms(s)? *(check all that apply)*

\_\_\_\_ Family move to a new home \_\_\_\_ Death of a family member \_\_\_\_ Development problems

\_\_\_\_ Birth of a child or sibling \_\_\_\_ Adjustment to a new job \_\_\_\_ Suspect physical/sexual abuse

\_\_\_\_ Fighting with spouse \_\_\_\_ Adjustment to school \_\_\_\_ Known physical/sexual abuse

\_\_\_\_ Post-divorce adjustment \_\_\_\_ Law violations \_\_\_\_ Alcohol/Substance abuse

\_\_\_\_ Financial stress \_\_\_\_ Dishonesty \_\_\_\_ Compulsive gambling/spending

\_\_\_\_ Martial unfaithfulness \_\_\_\_ Career concerns/unemployment \_\_\_\_ Pornography use

\_\_\_\_ Parenting problems \_\_\_\_ Empty nest \_\_\_\_ Anger/Violence

\_\_\_\_ Spiritual problems \_\_\_\_ Previous therapy \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health & Medical History**

12. Who is your primary care physician and your primary clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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13. Who else do you regularly see as part of your routine health care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. List any significant health problems, past or present, including surgeries and/or illness with ***corresponding dates.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Are you currently taking any medications? ☐ Yes ☐ No If Yes, please list:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dose and number of pills you take per day** | **Prescribing doctor** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

16. Have you ever taken any medications for depression, anxiety, or mental health issues? ☐ Yes ☐ No If Yes, please list:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Prescribed for?****(eg: depression, anxiety)** | **When (approx.)** | **How long were you on the medications?** | **Prescribing doctor** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

17. Do you have any allergies to medications? ☐ Yes ☐ No If Yes, please list and describe the reaction. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. List other therapy or counseling you have received in the past or are receiving now:

|  |  |  |
| --- | --- | --- |
| **Therapist’s name** | **Address** | **Approximate dates** |
|  |  |  |
|  |  |  |
|  |  |  |

19. If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form. To receive a Release of Information form, please check here: ☐

20. Have you ever been hospitalized for mental or nervous problems? Yes No If yes, when and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use**

21. Please describe your use of the following substances:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Daily** | **Weekly** | **Occasionally** | **In the past but not now** | **Not at all** |
| Caffeine |  |  |  |  |  |
| Tobacco |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Prescription drugs |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Street drugs |  |  |  |  |  |
| Over-the-counter medications |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

22. Have you ever experienced any of the following as a result of substance use?

☐ Blackouts ☐ Bad reactions ☐ Withdrawal symptoms ☐ Overdose ☐ DUI ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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23. Have you ever felt you should **cut down** on your drinking or drug use? ☐ Yes ☐ No

24. Have people **annoyed** you by criticizing your drinking or drug use? ☐ Yes ☐ No

25. Have you ever felt bad or **guilty** about your drinking or drug use? ☐ Yes ☐ No

26. Have you ever had a drink or used drugs as an **eye-opener** first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? ☐ Yes ☐ No

27. Have you ever had treatment for any type of alcohol or substance use? ☐ Yes ☐ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe: (including inpatient, outpatient, detox): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resources**

28. What has helped you manage or endure your current problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. Please describe the people in your life that currently play a supportive, influential, or friendship role. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. What interests or passions give you meaning to your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. Do you have any spiritual beliefs or practices that are important to you? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

32. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

33. Please list those who you consider part of your immediate family and/or your current household.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relation to you** | **Living with you?** |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |
|  |  |  | ☐ Yes ☐ No |

**Other**

34. Is there anything else that you would like your therapist to know and that you have not written about on any of these forms?

☐ Yes ☐ No If yes, please tell me about it here or on another paper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature and Date**

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my therapist of any changes in my personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

**Authorization for Release of Mental Health Treatment FOR INSURANCE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Insert Name of Patient/Client], whose Date of Birth is \_\_\_\_\_\_\_\_\_\_\_\_\_,

authorize Michelle Batz Counselingto disclose to and/or obtain from:

INSURANCE COMPANY NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information: [Insert Name of Person or Title of Person or Organization]

Contact information of person or organization:

**Description of Information to be Disclosed**

(Patient/Client should initial each item to be disclosed)

 \_\_\_\_ Assessment \_\_\_\_ Educational Information

 \_\_X\_\_ Diagnosis \_\_\_\_ Discharge/Transfer Summary

 \_\_\_\_ Psychosocial Evaluation \_\_\_\_ Continuing Care Plan

 \_\_\_\_ Psychological Evaluation \_\_\_\_ Progress in Treatment

 \_\_\_\_ Psychiatric Evaluation \_\_\_\_ Demographic Information

 \_\_\_\_ Treatment Plan or Summary \_\_\_\_ Psychotherapy Notes\*

 \_\_\_\_ Current Treatment Update (\* Cannot be combined with any other disclosure)

 \_\_\_\_ Medication Management Information \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_X\_\_ Presence/Participation in Treatment

 \_\_\_\_ Nursing/Medical Information **\_\_\_\_ Initial in agreement to all checked**

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to POB 307, Mount Gretna, PA 17064. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or as otherwise indicated: SIX MONTHS AFTER TREATMENT CEASES

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I have the right to request a copy of this authorization for my records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient/Client Date Signature of Parent, Guardian or Personal Rep Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Staff Witness Date

Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

**Authorization for Release of Mental Health Treatment ALL OTHER THAN INSURANCE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Insert Name of Patient/Client], whose Date of Birth is \_\_\_\_\_\_\_\_\_\_\_\_\_,

authorize Michelle Batz Counselingto disclose to and/or obtain from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information:

[Insert Name of Person or Title of Person or Organization]

Contact information of person or organization:

**Description of Information to be Disclosed**

(Patient/Client should initial each item to be disclosed)

 \_\_\_\_ Assessment \_\_\_\_ Educational Information

 \_\_\_\_ Diagnosis \_\_\_\_ Discharge/Transfer Summary

 \_\_\_\_ Psychosocial Evaluation \_\_\_\_ Continuing Care Plan

 \_\_\_\_ Psychological Evaluation \_\_\_\_ Progress in Treatment

 \_\_\_\_ Psychiatric Evaluation \_\_\_\_ Demographic Information

 \_\_\_\_ Treatment Plan or Summary \_\_\_\_ Psychotherapy Notes\*

 \_\_\_\_ Current Treatment Update (\* Cannot be combined with any other disclosure)

 \_\_\_\_ Medication Management Information \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Presence/Participation in Treatment

 \_\_\_\_ Nursing/Medical Information **\_\_\_\_ Initial in agreement to all checked**

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or as otherwise indicated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I have the right to request a copy of this authorization for my records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient/Client Date Signature of Parent, Guardian or Personal Rep Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Staff Witness Date

Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

***INFORMED CONSENT***

**Insurance Verification & Billing**

I hereby authorize Michelle Batz Counseling as Service agent for Michelle Batz, LCSW and Michelle Batz Counseling (Facility), to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by Michelle Batz, LCSWproviding mental health counseling. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the Counselor and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the Counselor or facility.

The following also applies to the use of my insurance to cover the cost of services rendered:

**Authorization to Release Medical Information For Billing**

☐ I hereby authorize the release of any information regarding services by the Counselor/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims.

**Assignment of Insurance Benefit**

☐ I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the Counselor and the facility made directly to the Counselor and/or the facility.

**Financial Responsibility**

☐ I understand that I am responsible for any fees not covered by insurance.

**Authorization for the Release of Medical Information for Treatment**

☐ I hereby authorize the above Counselor and facility to obtain and release copies of my medical records and information regarding my medical history, mental or physical conditions for the purpose of further treatment and evaluation.

**PATIENT INFORMATION**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)**

**\_\_\_\_ CHECK HERE IF SAME AS PATIENT**

**Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION**

**Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient relationship to insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a secondary insurance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**R112021**

Michelle Batz Counseling

**MENTAL HEALTH COUNSELING**

**Notice of Privacy Practices and Practice Limitations**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.**

**We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person’s estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 717-644-1868.

** Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

** Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

** Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

** Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

** Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

** Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

** Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 717-644-1868 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

**Practice limitations:**

Due to the natures of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be considered confidential, it is agreed that should there be legal proceedings such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc., neither you, your attorney(ies) nor anyone else acting on your behalf will call upon me to testify in court or at any other proceeding or to provide custody evaluation recommendations. Furthermore, I do not provide legal advice nor prescribe medicine as both these actions fall outside my scope of practice and my regulatory, statutory and licensed authority.