

HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

5610 Crawfordsville Road, Suite 200
Indianapolis, Indiana 46224-3714
Phone: (317) 241-HOPE 4673 Fax: (317) 241-0201
www.hopehavenpsych.org

ADULT Services Intake

Please complete the following information; all data will be kept CONFIDENTIAL

[Name Field] [Date of Birth Field] [Age Field]

Name Date of Birth Age

[Address Field] [Apt#/Suites/Lot Field] [City/State Field]

Address Apt#/Suites/Lot City/State

[Zip Code Field] [Home Phone Field] [Additional Phone Field]

Zip Code Home Phone Additional Phone
Is it ok to leave a message? Is it ok to leave a message?

[Referred by or at the suggestion of Field]

Referred by or at the suggestion of

[Family Physician Field] [Your # of Yrs. in School Field]

Family Physician Your # of Yrs. in School

[Your Highest Grade Completed Field]

Your Highest Grade Completed

Please Share Why You Are Seeking Therapy Services

[Please Share Why You Are Seeking Therapy Services Field]

Previous Mental Health Care

Year Services began; Timespan, Name of Provider, Reason services began

[Previous Mental Health Care Field]

Current Mental Health Care

Year Services Began, Timespan, Name of Provider, Reason services began and are being changed

[Current Mental Health Care Field]

Have you ever been hospitalized for mental health or substance abuse treatment?

If yes, please note

Year Services were received, Length of Time in Hospital, Name of Hospital, Reason for admission

[Hospitalization Field]

How would you describe your general mood and feelings

[How would you describe your general mood and feelings Field]

Briefly discuss any type(s) of mental health concerns/treatment, specific to your immediate family

Please share any experience(s) you have had with childhood or adult Abuse or Trauma/Domestic Violence

LEGAL HISTORY

Briefly discuss personal previous/current legal history, including arrest, detentions, and litigation

Briefly discuss immediate family member's previous/current legal history, including arrest, detentions, and litigation

SUBSTANCE ABUSE HISTORY

Briefly discuss any type(s) of substances use, frequency, and last usage with self

Briefly discuss any type(s) of major substances use, frequency, and last usage with immediate family

Please share any concerns you might have regarding your substance use

MEDICAL HISTORY

Briefly discuss current major medical/physical concerns with self

Briefly discuss any type(s) of major medical concerns with immediate family

Please list any Significant Past Injuries, Illnesses, or Surgeries
Current Medications

RESIDENTIAL MAKE-UP

Current Individuals Residing with you who are not dependents
(Name, Age, Type of Employ)

RELATIONSHIP STATUS

Single Separated Length of Time

Partnered Length of Time Divorced Length of Time

Married Length of Time Widowed Length of Time

How many times have you been married?

Reason(s) for separation/divorce

Sexual Orientation

Sexuality/Intimacy Concerns

FAMILY MAKE-UP

Children: Name, Age, Gender, Grade Level/Occupation)

Siblings: Name, Age, Gender, Grade Level/Occupation)

Biological Parents: Name, Age, Gender, Education/Occupation)

Adoptive/Step Parents: Name, Age, Gender, Education//Occupation)

EDUCATIONAL HISTORY

(Educational Institution, Grade Level/Degree Received, Last Grade Attended/Date Received, Reason for not completing if applicable)

WORK HISTORY

Current Place of Employment, Type of Work, Month and Year of Start Date

Satisfaction or Areas of Concern with current employment

Previous Place of Employment, Type of Work within the last 5 years

Total Gross (before taxes) Household Income for the previous year

MILITARY HISTORY

Yes Branch of Service Number of Years

Type of Discharge

Please share information about your major life stressors within the last 3 MONTHS

Please also rate each stress from 0 (Not to Stressful) to 10 (Very Stressful)

How do you usually cope with your stress?

What goals would you like to accomplish in therapy?

[Empty text box for goals]

AVAILABILITY

(please check ALL that apply)

Monday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>
Tuesday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>
Wednesday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>
Thursday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>
Friday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>
Saturday <input type="checkbox"/>	Morning (8am-11) <input type="checkbox"/>	Afternoon (12-4pm) <input type="checkbox"/>	Evening (after 5pm) <input type="checkbox"/>

INSURANCE

Client's Name	<input type="text"/>	Client's Birthdate	<input type="text"/>
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Client's Insurance Member ID Number	<input type="text"/>	Policy Holder's Name	<input type="text"/>
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Client's Relationships To Policy Holder	<input type="text"/>	Policy Holder's SSN	<input type="text"/>
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Insurance Policy Group Number	<input type="text"/>
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Provider Relations/Pre-Certification Phone Number(s) on Back of Your Insurance Card	<input type="text"/>
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<input type="text"/>	<input type="text"/>
Client Signature (First MI Last)	Date

Electronic Signature

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Witness/Psychological Prof. Signature	Date	Legal Authority of Representative
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Electronic Signature

Name:

Date:

ANXIETY Screening

Below is a list of common symptoms of **anxiety**. Please read the items carefully and honestly indicate how much you have been bothered during the last **MONTH** including today by the experienced symptoms. Read through the items and circle the number that corresponds to how life has recently been for you.

Experienced Anxiety Symptom	<u>NONE</u> I have no experience with this	<u>MILD</u> It happens a little bit but it does not really bother me. It does not happen often.	<u>MODERATE</u> Feels pretty frequent (often) and it has not been pleasant. I am starting to notice is more.	<u>SEVERE</u> It bothers me a lot and it feels like all the time. It seems to happen more than I can count.
Numbness or Tingling	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Picking Sores, Nail-Biting, Rubbing Head and causing Sores, Pulling Hair, etc.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Wobbly Legs-no medical concern	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Unable to Relax	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Fear the Worst Happening	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Dizzy, Lightheaded, Faint	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Heart Pounding or Racing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Feeling on Edge	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Terrified, Afraid, Scared	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Nervous	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Feeling like you are choking	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hands, Legs, Trembling or Other body twitches-no medical concern	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Feeling Jittery	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Fear of Losing Control	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Having a hard time breathing-no medical concern	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Frequent fear and thoughts about dying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Thinking about things over and over	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Ingestion Problems (constipation, diarrhea, upset stomach, etc.)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Worrying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hot or Cold Sweats	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Try to avoid certain places and people	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Cant seem to calm down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Stressed	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
COLUMN SUM				

Name:

DEPRESSION Screening

Below is a list of common symptoms of **depression**. Please read the items carefully and honestly indicate how much you have been bothered during the last **MONTH** including today by the experienced symptoms. Read through the items and circle the number that corresponds to how life has recently been for you.

Experienced Depression Symptom	<u>NONE</u> I have no experience with this	<u>MILD</u> It happens a little bit but it does not really bother me. It does not happen often.	<u>MODERATE</u> Feels pretty frequent (often) and it has not been pleasant. I am starting to notice is more.	<u>SEVERE</u> It bothers me a lot and it feels like all the time. It seems to happen more than I can count.
Feeling Irritable	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Sad	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
My view of the future is discouraging	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I feel like a failure	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I can never do anything right	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
It has been hard to like myself	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
It seems like I am being punished	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I blame myself for everything	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Not wanting to be bothered	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I am so tired of crying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I sleep most of the day	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I just don't feel like eating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
It is hard for me to make decisions	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Being able to concentrate has been hard	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Very little seems interesting to me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
My energy is so low	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
No one seems to care about me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I can't seem to sleep these days	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I crave food all the time	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I wish it would all end	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Extremely happy and energetic for no reason	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Up and Down Moods	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Nothing seems to matter anymore	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
COLUMN SUM				

Name:

SUBSTANCE ABUSE Screening

Below is a list of common symptoms of **Substance Abuse**. Please read the items carefully and honestly indicate how much you have been bothered during the last **MONTH** including today by the experienced symptoms. Read through the items and circle the number that corresponds to how life has recently been for you.

Experienced Substance Abuse Symptom	<u>NONE</u> I have no experience with this	<u>MILD</u> It happens a little bit but it does not really bother me. It does not happen often.	<u>MODERATE</u> Feels pretty frequent (often) and it has not been pleasant. I am starting to notice is more.	<u>SEVERE</u> It bothers me a lot and it feels like all the time. It seems to happen more than I can count.
I need a drink or drug every now and then	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Drugs and alcohol help me to relax	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have been in trouble with the law because of my drinking or drug usage	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have used drugs or alcohol at work	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have family members who have had a hard time with drugs or alcohol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I argue with others about my drinking or drug use	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
It takes a lot for me to get drunk or high (more of the substance)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Alcohol or drugs seems to be the only things that keep me going	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Drinking or using drugs is better alone	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I can't seem to enjoy myself without drugs or alcohol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I hide how much I drink or use drugs from others	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Drinking or using drugs helps me to deal with it all	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I spend a lot of time thinking about how I can get my next drink or fix	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have went for a drink or used drugs early in the morning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I started using drugs or drinking when I was a teenager	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have spent money I did not have on alcohol or drugs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I have taken medicine not prescribed to me	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I need drugs/alcohol to get through my day	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
There are some things I don't remember when I am drinking or using drugs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Others around me think I have a problem with drugs or alcohol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
I feel bad about how much I drink or use drugs	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
COLUMN SUM				

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

NAME: _____

Date: _____

Circle the Yes or No for each item

1. Did a parent or other adult in the household OFTEN (more days than not) swear at you, insult you, put you down, or humiliate you? Or EVER Act in a way that made you afraid that you might be physically hurt?	YES	NO
2. Did a parent or other adult in the household OFTEN push, grab, slap, or throw something at you? Or EVER hit you so hard that you had marks or were injured?	YES	NO
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? Or Try to or actually have oral, anal, or vaginal sex with you?	YES	NO
4. Did you OFTEN feel that no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?	YES	NO
5. Did you OFTEN feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES	NO
6. Were your parents EVER separated or divorced?	YES	NO
7. Was your mother or stepmother OFTEN pushed, grabbed, slapped, or had something thrown at her? Or SOMETIMES or OFTEN kicked, bitten, hit with a fist, or hit with something hard? Or EVER repeatedly hit over at least a few minutes or threatened with a gun or knife? ____	YES	NO
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES	NO
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	YES	NO
10. Did a household member go to prison?	YES	NO

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Therapist-Client Service Agreement

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that Hope Haven Psychological Resource, LLC, provide you with a **Notice of Policies and Practices at Hope Haven Psychological Resource, LLC, to Protect the Privacy of your Health Information** (the “notice”). This notice will explain HIPAA and its application to your personal health information in greater detail. Please read this Agreement and the Notice carefully. We will request that you sign the Notice of Privacy Practices acknowledging that we have provided you with this information. We will discuss any questions that you have about this Agreement and the Notice. Your signature on this Therapist-Client Services Agreement will constitute a binding agreement between you and Hope Haven Psychological Resource, LLC. Furthermore, this will also serve as consent to begin psychological services with you and/or your minor aged child (client).

EMERGENCIES

In the event of a life threatening emergency, please dial 911 or one of the following emergency numbers

Community Hospital Crisis	621-5700, 800-662-3445	St Francis Crisis	317-782-6495
Valle Vista Crisis	800-447-1348	St Vincent Crisis	317-338-4800
Wishard-Midtown CMHC	317-630-7791	Clarian Health Crisis	317-962-2622

PROFESSIONAL SERVICES

All records will be kept pursuant of HIPAA. Except in unusual circumstances that involve potential danger to yourself or others, you may examine and/or receive a copy of your Clinical/Treatment Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with the mental health professional so that the contents can be discussed.

Upon request and written (signed) Authorization, you may have a copy of your Clinical/Treatment Record forwarded to another mental health professional so you can discuss the content. The exceptions to this policy are contained in the Notice of Privacy.

A fee of \$0.25 per page will be charged for copying your records.

CONFIDENTIALITY

The law protects the privacy of all communication between a Client and a Mental Health Professional. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Therapist-Client Services Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a clinical situation. During a consultation, I will avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our professional work. I will note all consultations in your clinical record (which is called Protected Health Information [PHI] in the Notice of Policies and Practices at Hope Haven Psychological Resources, LLC, to Protect the Privacy of your Health Information).
- If a Client seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or contact family members or others who can help provide protection. I may disclose confidential information only to medical or law enforcement personnel if I determine that there is a probability of imminent physical injury by the Client to himself/herself or others.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in court proceedings and a request is made for information concerning your diagnosis and treatment, such information is protected by privilege/confidentiality laws. I cannot provide any information without your (or your legal representative's) written/signed Authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether court action may possibly order Hope Haven Psychological Resource, LLC to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a Client files a complaint or lawsuit against me, I may disclose relevant information regarding that Client in order to defend myself.
- If you file a worker's compensation claim, I may be required to disclose PHI, such as diagnosis and Clinical/Treatment records (Psychotherapy Notes), to relevant parties or officials.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect yourself and/or others from harm, and I may have to reveal some information about a Client's treatment.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, I must report that belief, as required by law, to the appropriate authorities. Once such a report is filed, I may be required to provide additional information.
- If I determine that there is a probability that the Client will inflict imminent physical injury to another, or that the Client will inflict imminent physical harm upon himself/herself, I will be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the Client.

If such a situation arises, I will make every effort to fully discuss it with you before taking action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any question or

concerns that you have now or in the future. In situations where specific advice is required, formal legal advice may be needed.

CLIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical/Treatment Records and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical/Treatment Record is disclosed to others; requesting an accounting of disclosures of PHI; determining the location that protected information disclosures are sent; having any complaints you make about Hope Haven Psychological Resource LLC's policies and procedures recorded in your records; and the right to have a paper copy of this agreement, the Notice of Privacy and Practices form, and the privacy policies and procedures at Hope Haven Psychological Resources, LLC.

ADDITIONAL INFORMATION

You have the right to choose not to receive services from Hope Haven Psychological Resource, LLC at any time. If you choose this, you will be provided with names of other qualified professionals whose services you may prefer. You also have the right to ask any questions about the procedures used in practice. I encourage you to ask questions about Hope Haven Psychological Resource, LLC methods as they arise. I encourage you to ask question you may have about the structure of a therapist-client relationship or the nature of services at any time. Please feel free to discuss with me any problem that may arise regarding any of these policies.

AGREEMENT AND CONSENT FOR TREATMENT

<input type="text"/>	<input type="text"/>	<input type="text"/>
Client Name	Date of Birth	Age

<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	City/State	Zip Code

<input type="text"/>	Permission to leave message at this number (with the person answering the phone, answering machine and/or voice mail) <input type="checkbox"/> YES <input type="checkbox"/> NO
Home Phone	

<input type="text"/>	Permission to leave message at this number (with the person answering the phone, answering machine and/or voice mail) <input type="checkbox"/> YES <input type="checkbox"/> NO
Work Phone	

If Client is a minor-aged child:

<input type="text"/>	<input type="text"/>
Parent/Legal Guardian/Representative	Relationship to Child

<input type="text"/>	Permission to leave message at this number (as stated above) <input type="checkbox"/> YES <input type="checkbox"/> NO
Home/Additional Contact Phone	

<input type="text"/>	Permission to leave message at this Number (as stated above) <input type="checkbox"/> YES <input type="checkbox"/> NO
Work Phone	

In the event of an EMERGENCY, permission to contact next of kin: YES NO

If YES, Name:

Phone Number:

I have read this Therapist-Client Service Agreement and the Notice of Policies and Practices at Hope Haven Psychological Resource, LLC, to protect the privacy of your health information fully and completely, I have discussed any questions I had about the information, and understand the information. I understand that there are no guarantees stated or implied, and I accept the risk inherent in the course of psychological service. I understand the payment, charges, and fees for services provided by Hope Haven Psychological Resources, LLC. I agree to hold Hope Haven Psychological Resource, LLC harmless for any injury or claim of damages arising from release of records or information to my insurance company/manage care company, Medicaid, or collection agency.

(Parent/Legal Guardian/Representative/Responsible Party)

Agreement and the Notice of Policies and Practices at Hope Haven Psychological Resource, LLC, to protect the privacy of your health information fully and completely, I have discussed any questions I had about the information, and understand the information. I understand that there are no guarantees stated or implied, and I accept the risk inherent in the course of psychological service. I understand the payment, charges, and fees for services provided by Hope Haven Psychological Resources, LLC. I agree to hold Hope Haven Psychological Resource, LLC harmless for any injury or claim of damages arising from release of records or information to my insurance company/manage care company, Medicaid, or collection agency.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Client Signature (First MI Last)	Date	Parent/Guardian/Representative Sign.	Date
Electronic Signature <input type="checkbox"/>		Electronic Signature <input type="checkbox"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness/Psychological Prof. Signature	Date	Legal Authority of Representative
Electronic Signature <input type="checkbox"/>		

Print: Psychological Prof Name and Credentials

I have read and I understand that this (Parent/Legal Guardian/Representative/Responsible Party)

Therapist-Client will constitute a binding agreement between Hope Haven Psychological Resource, LLC, and I agree to abide by its terms during our professional relationship. I agree and consent to participate in mental health services (for me or my minor-aged child) offered through Hope Haven Psychological Resources, LLC. I understand that I am consenting and agreeing only to those mental health services that the psychological professional is qualified to provide within the scope of his/her certification and training.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Client Signature (First MI Last)	Date	Parent/Guardian/Representative Sign.	Date
Electronic Signature <input type="checkbox"/>		Electronic Signature <input type="checkbox"/>	

<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness/Psychological Prof. Signature	Date	Legal Authority of Representative
Electronic Signature <input type="checkbox"/>		

Print: Psychological Professional Name and Credentials

HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

5610 Crawfordsville Road, Suite 200
Indianapolis, Indiana 46224-3714
Phone: (317) 241-HOPE 4673 Fax: (317) 241-0201
www.hopehavenpsych.org

Notice of Policies and Practices at Hope Haven Psychological Resources, LLC, to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (WHICH INCLUDES YOUR MINOR-AGED CHILD, IF HE/SHE IS THE IDENTIFIED CLIENT) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI) for treatment, payment, and health care operations purposes with your written consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you
- “Treatment, Payment and Health Care Operations”
 - Treatment is when a Mental Health Professional provides, coordinates or manages your health care and other services related to your health care. An example of treatment includes when a Mental Health Professional consults with another health care provider, such as your family physician or another mental health professional.
 - Payment is when I obtained reimbursement for your healthcare.
 - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Uses” applies only to activities within this office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosures” applies to activities outside of this office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session (or telephone conversation pertinent to any counseling session), which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) This agency has relied on

that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the police.

III. Uses and Disclosures with Neither Consent nor Authorization

This agency may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse:* If this agency has reasonable cause to believe that a child has been abused, we must report that belief, as required by law, to the appropriate authorities.
- *Adult and Domestic Abuse:* If this agency has reasonable cause to believe that a disable adult or elder person has had a physical injury or injuries upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, this agency must report that belief, as required by law, to the appropriate authorities.
- *Health Oversight Activities:* If a government agency, such as the Indiana Attorney General's Office is conducting an investigation into my practice, then this agency is required to disclose PHI upon receipt of a subpoena.
- *Judicial and Administrative Proceedings:* If the patient is involved in a court proceeding and a request is made for information about the professional services this agency provided you and/or the record thereof, such information is privileged under state law, and this agency will not release information without the written authorization of you (or your legally appointed representative) or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety:* If this agency determines, or pursuant to the standards of this agency's profession should determine, that you present a clear and immediate probability of physical harm to yourself, to other individual(s), or to society, this agency may communicate relevant information concerning this to the potential victim, appropriate family member, medical or law enforcement personnel, or other appropriate authorities.
- *Worker's Compensation:* If you file a worker's compensation claim, this agency may be required to disclose PHI, such as your diagnosis and treatment records, to relevant parties or officials. This agency may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs (e.g., SSI), established by law that provide benefits for work-related injuries or illness without regard to fault.

IV. Client's Rights and Therapist Duties

Client's Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosure of PHI. However, this agency is not required to agree to a restriction you request.
- *Right to Receive Confidential Communication by Alternate Means and Alternate Locations:* You have the right to request and receive confidential communications of PHI by alternate means and at alternate locations (e.g., you may not want a family member to know you are seeing a psychological professional for treatment. Upon your request, this agency will send correspondence to another address.)
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in this agency's mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. This agency may deny your access to PHI under certain circumstances, but in

some cases you may have this decision reviewed. On your request, this agency will discuss with you the details of the request and denial process.

- *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This agency may deny your request. On your request, this agency will discuss with you the details of the amendment process.
- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI. On your request, this agency will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* you will be provided a paper copy of this notice from this agency and will be asked to acknowledge receipt of this notice.

Agency Duties:

- This agency is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- This agency reserves the right to change the privacy and policies and practices described in this notice. Unless this agency notifies you of such changes; however, this agency is required to abide by the terms currently in effect.
- If this agency revises the policies and procedures, this agency will provide you with a written copy of those revisions at the next appointment or by mail.

V. Complaints

If you are concerned that this agency violated your privacy rights, or you disagree with a decision this agency made about access to your records, you may contact the administrative office at the above phone and/or address.

You may also send a written complaint to the Indiana State Department of Health and the Secretary of the U.S. Department of Health and Human Services. This agency can provide you with the appropriate addresses upon request.

You have specific rights under the Privacy Rule. This agency will take no retaliatory action against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This Notice, pursuant to the Health Insurance Portability and Accountability Act (HIPAA), has been in effect since April 14, 2003. This agency reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that this agency maintained. This agency will provide you with a revised notice in person or by mail.

I have reviewed, understand, and received a paper copy of the **“Notice of Policies and Practices at Hope Haven Psychological Resources, LLC, to Protect the Privacy of Your Health Information”** from a psychological professional.

VII. Signatures

Client Name (First MI Last)

Date of Birth

Age

Client Signature

Electronic Signature

Date

Parent/Guardian/Representative Sign.

Electronic Signature

Date

Witness/Psychological Prof. Signature

Electronic Signature

Date

Legal Authority of Representative

Print: Psychological Prof Name and Credentials

HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

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5610 Crawfordsville Road, Suite 200
Indianapolis, Indiana 46224-3739
Phone: (317) 241-HOPE 4673 Fax: (317) 241-0201
www.hopehavenpsych.org

Acknowledgement of Receipt of Notice of Privacy Practices

PLEASE SIGN YOUR NAME, PRINT YOUR NAME, AND NOTE THE DATE ON WHICH YOU SIGNED THIS ACKNOWLEDGEMENT FORM REGARDING RECEIPT (OR DECLINE OF COPY) OF THE NOTICE OF POLICIES AND PRACTICES AT HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

This acknowledgement is in regards to your Protected Health Information (PHI) in compliance with and pursuant of the Health Insurance Portability and Accountability Act (HIPAA)

I. Signatures

Client Name (First MJ Last) PLEASE PRINT Date of Birth Age

Client Signature Date Parent/Guardian/Representative Sign. Date
Electronic Signature Electronic Signature

BY CHECKING THIS BOX I AM DECLINING A COPY OF THE NOTICE OF POLICIES AND PRACTICES AT HOPE HAVEN PSYCHOLOGICAL RESOURCE.

Witness/Psychological Prof. Signature Date Legal Authority of Representative
Electronic Signature

Print: Psychological Prof. Name and Credentials

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HOOSIER HEALTHWISE-CARE SELECT FEE POLICIES AND PROCEDURES

Please sign below to indicate your understanding of the following policies and procedures:

- 1. The sliding fee for Individual Therapy ranges from \$40.00 to \$75.00 per session without insurance. Group sessions are less and based on the length of the sessions. If your insurance were to lapse this is the fee that you would be expected to pay.
2. FEES are to be paid at the time of the services rendered, if applicable.
3. To receive a sliding fee scale, you will be asked to show verification of income/verification of student status/unemployment/disability, etc. every 6 months. All income including SSI disability, unemployment, TANF, alimony, etc. is used in determining fees. Until verification of gross household income is received, you will be charged the full fee.
4. If you have insurance coverage, we will bill the insurance company for the full fee.
5. If you must cancel or reschedule an appointment for services you are required to call 24 hours in advance.
6. If you miss TWO consecutive appointments without 24 hour notice your appointment time may not be reserved for you.
7. Please notify the office/your therapist if your contact information has changed, being sure to inform the office of specific instructions with regards to contacting you.
8. Please be available, on time, for your appointment. If you are late, you will only have the remaining portion of your session.

If you have any concerns or complaints regarding your treatment please express your thoughts to your therapist. If you are still dissatisfied, you will be welcomed to have communication with the agency owner.

I. Signatures

Form fields for Client Name, Date of Birth, and Age.

Client Name (First MI Last) PLEASE PRINT

Date of Birth

Age

Form fields for Client Signature, Date, Parent/Guardian/Representative Sign., and Date.

Client Signature

Date

Parent/Guardian/Representative Sign.

Date

Electronic Signature [checkbox]

Electronic Signature [checkbox]

Form fields for Witness/Prof. Signature, Date, and Legal Authority of Representative.

Witness/Psychological Prof. Signature

Date

Legal Authority of Representative

Electronic Signature [checkbox]

Form field for Print: Psychological Prof Name and Credentials.

Print: Psychological Prof Name and Credentials

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Form fields for Patient Name, Date of Birth, Age, Address, Apt#/Suites/Lot, City/State, Zip Code, Home Phone, Work Phone, Social Security Number.

I hereby authorize and request that Hope Haven Psychological Resource, LLC:

Release/Disclose/Exchange Information to: Obtain Information from:

Name/Agency

Form fields for Address, Apt#/Suites/Lot, City/State, Zip Code, Phone Number, Fax Number.

Purposes for the Release/Disclosure of Protected Health Information:

At the Request of the patient (or legal guardian): Obtain Information From:

The Protected Health Information to be Released/Disclosed:

- Entire Records, Initial Evaluation, Diagnoses, Psychotherapy Notes, Attended Sessions, Psychological Report/Testing, School Behavior Records, Medications/Medical History, Treatment Plans, Treatment Summary, Discharge Summary, Billing Records, Other:

Protected Health Information to be Released/Disclosed

- Verbally, U.S. Postal Service, Fax, Photocopy, Other

I understand that these records may contain information related to behavioral or mental health (psychological) services, HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse. I give my specific authorization for these records to be released/disclosed.

I understand that I have the right to revoke this authorization at any time by providing written notification to Hope Haven Psychological Resources, LLC.

I understand that any such revocation will not be effective to the extent that Hope Haven Psychological Resource, LLC, has already taken action in response to this authorization or if otherwise required by legal contract or court order.

I understand that any information released/disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it will no longer be protected by this authorization.

I understand that I am not required to sign this authorization and that my treatment will not be affected if I refuse to sign this authorization.

I understand that this authorization will expire on (date). If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date it was signed.

I understand that a copy or facsimile (fax) of this authorization is as valid as the original.

I understand that I have the right to receive a copy of this authorization.

My initials indicate my receipt of a Copy of this Authorization

I hereby release Hope Haven Psychological Resource, LLC from any and all liability and injuries that may arise from the disclosure of this information to the party named above. I have read the above or had it read to me and I authorize the release/disclosure of the Protected Health Information Stated above.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Client Signature (First MI Last) Electronic Signature <input type="checkbox"/>	Date	Parent/Guardian/Representative Sign. Electronic Signature <input type="checkbox"/>	Date

<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness/Psychological Prof. Signature Electronic Signature <input type="checkbox"/>	Date	Legal Authority of Representative

Print: Psychological Professional Name and Credentials

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Form fields for Patient Name, Date of Birth, Age, Address, Apt#/Suites/Lot, City/State, Zip Code, Home Phone, Work Phone, and Social Security Number.

I hereby authorize and request that Hope Haven Psychological Resource, LLC:

Form fields for Release/Disclose/Exchange Information to: Benetta E. Johnson, Ph.D., HSPP and Obtain Information from: Benetta E. Johnson, Ph.D., HSPP, Licensed Counseling Psychologist, Supervisor

Name/Agency

Form fields for Name/Agency: 5610 Crawfordsville Road, 200, Indianapolis, Indiana, 46224, 317-241-4673, 317-241-0201

Purposes for the Release/Disclosure of Protected Health Information:

Form fields for Purposes for the Release/Disclosure of Protected Health Information: Quality Clinical Care/Best Practices/Treatment Review, Insurance Requirement/Mandate

The Protected Health Information to be Released/Disclosed:

Form fields for The Protected Health Information to be Released/Disclosed: Entire Records, Attended Sessions, Treatment Plans, Initial Evaluation, Psychological Report/Testing, Treatment Summary, Diagnoses, School Behavior Records, Discharge Summary, Psychotherapy Notes, Medications/Medical History, Billing Records, Other

Protected Health Information to be Released/Disclosed

Form fields for Protected Health Information to be Released/Disclosed: Verbally, U.S. Postal Service, Fax, Photocopy, Other, Electronic Copies

I understand that these records may contain information related to behavioral or mental health (psychological) services, HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse. I give my specific authorization for these records to be released/disclosed.

I understand that I have the right to revoke this authorization at any time by providing written notification to Hope Haven Psychological Resources, LLC.

I understand that any such revocation will not be effective to the extent that Hope Haven Psychological Resource, LLC, has already taken action in response to this authorization or if otherwise required by legal contract or court order.

I understand that any information released/disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it will no longer be protected by this authorization.

I understand that I am not required to sign this authorization and that my treatment will not be affected if I refuse to sign this authorization.

I understand that this authorization will expire on (date: **RECOMMENDED, TWO years from date of signature**). If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date it was signed.

I understand that a copy or facsimile (fax) of this authorization is as valid as the original.

I understand that I have the right to receive a copy of this authorization.

My initials indicate my receipt of a Copy of this Authorization

I hereby release Hope Haven Psychological Resource, LLC from any and all liability and injuries that may arise from the disclosure of this information to the party named above. I have read the above or had it read to me and I authorize the release/disclosure of the Protected Health Information Stated above.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Client Signature (First MI Last) Electronic Signature <input type="checkbox"/>	Date	Parent/Guardian/Representative Sign. Electronic Signature <input type="checkbox"/>	Date

<input type="text"/>	<input type="text"/>	<input type="text"/>
Witness/Psychological Prof. Signature Electronic Signature <input type="checkbox"/>	Date	Legal Authority of Representative

Print: Psychological Professional Name and Credentials



BEHAVIORAL / PHYSICAL HEALTH COORDINATION

State Form 51856 (R / 9-04) / OMPP 0016
Family & Social Services Administration
Office of Medicaid Policy & Planning

IMPORTANT (PLEASE READ): This form may contain protected health information from the INDIANA HEALTH COVERAGE PROGRAMS (IHCP), which is intended only for the use of the individual or entity named in this form. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure or reproduction of this information is prohibited. Any unintended recipient should contact the sender immediately.

Insurer patient identification number		Date (month, day, year)	
Name of member		Date of birth (month, day, year)	
Health care provider		Behavioral health provider Hope Haven Psychological Resource, LLC	
Address (number and street)		Address (number and street) 5610 Crawfordsville Road, Suite 200	
City, state, ZIP code		City, state, ZIP code Indianapolis, Indiana 46224	
Telephone number ()	Fax number ()	Telephone number (317) 241-4673	Fax number (317) 241-0201

This form was filled out by
self and Hope Haven Psychological Resource, LLC

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

More information: www.indianamedicaid.com

PATIENT CONSENT

Please check if you **DO NOT** want the following protected health information released: Behavioral Health Substance Abuse HIV/AIDS

This authorization will expire on _____. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by Hope Haven Psychological Resource will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed

Name of provider

Signature of member

by the recipient and may no longer be protected.

Signature of member

Member declined to participate

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			-----
2.			Current diagnosis:
3.			-----
4.			Comments:
5.			-----
6.			-----

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			-----
2.			Current diagnosis:
3.			-----
4.			Comments:
5.			-----
6.			-----

Please provide the following information regarding (Member name)

2. Is another appointment required? If yes, date and time scheduled AM PM
 Yes No

1. Results of appointment, including any prescriptions ordered (attach forms as necessary)

3. Are there any special instructions for this member to follow? (please describe)

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Text Notification/Messaging Usage Policy and Consent Form

- Hope Haven Psychological Resource offers Text Message notifications for appointment reminders and other client care communication.
- This system will allow you to verify an appointment and to keep you informed of office and client care information.
- Each Hope Haven therapist has a direct mobile number which allows you to communicate with them via text.
- You will be given your assigned therapist's number to use for scheduling purposes only. (i.e. canceling, rescheduling or confirming appointments)
- To protect your privacy, Hope Haven asks that you do not share specific personal information via text or email with the office or your therapist.
- Hope Haven asks that you do not send personal pictures of yourself/dependents, your insurance information, medical records, voice recordings, forwarded messages or protected health documentation via text messaging.
- Hope Haven asks that you do not use your/dependents first and last name in a text message. Please use your initials OR your first name only OR your last name only.
- This information is only used for Hope Haven Psychological Resource purposes and is governed by the same HIPAA protection as all other protected health information.
- Standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I DO NOT authorize Hope Haven Psychological Resource and/or my therapist to notify me of patient care related information via text messaging or email.

I authorize Hope Haven Psychological Resource and/or my therapist to notify me of patient care related information via text messaging or email.

I agree to only share information regarding scheduling with my therapist via text messaging.

I agree to comply with this Usage policy, as stated above.

I am aware that I can safely communicate with my therapist by having a confidential phone call or Therapy appointment

Your Name: _____

Client's Name: _____

Text Number: (____) _____

(If different from previous name)

Client/Parent/Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

I received a copy of this policy and consent form. (Please initial)

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WAITING AREA POLICY

For the safety of you, your family, other clients and staff, we have a few general rules about our waiting areas:

1. **Please don't leave young children unattended in the waiting room.** Children under age 12 cannot be left alone in our waiting areas. Prior approval by your therapist is required for children to sit in Adult sessions.
2. **Parents/Guardians are discouraged from leaving the property while their child is in session.** If you need to leave please inform your therapist and/or the receptionist before exiting; please return before the end of the session.
3. **Respect the privacy of others who are waiting.** Please *do not* ask other people why they are here - even if they look friendly and approachable.
4. **Please be quiet.** Some clients are more sensitive than others. Sound and conversation can easily distract them from the healing they need during their session. Please help us to maintain a calm and quiet space to help in the healing process of our clients.
5. **Please protect your confidentiality.** Your phone conversations are private. If you need to make/take a call, please take the call *outside* of our waiting area to ensure confidentiality.
6. **Please don't eat in our waiting areas.**
7. **You are welcome to bring toys or (silent) games to occupy young children, and remind them to use their "inside" voices.**

It is our hope that you find peace and comfort in our waiting areas.

I agree to comply with this Waiting Room policy, as stated above.

Client Name (Printed): _____

Client/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____