HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

5610 Crawfordsville Road, Suite 200
Indianapolis, Indiana 46224-3714
Phone: (317) 241-HOPE 4674 Fax: (317) 241-0201
www.hopehavenpsych.org

Application for YOUTH Services-General

Client's Name | Date of Birth | Age

Your Name | Your Relationship to Client

Address | Apt#/Suites/Lot | City/State

Zip Code | Home Phone | Additional Phone | Social Security Number

Referred by or at the suggestion of

Family Physician or Client Pediatrician | # of Yrs in School | Highest Grade Completed

NON-CUSTODIAL/JOINT CUSTODIAL PARENT'S INFORMATION (if applicable)

Other Parent's Name | Relationship to Client

Address | Apt#/Suites/Lot | City/State

Zip Code | Home Phone | Additional Phone | Email

Please Explain Why You Would Like this Youth to begin therapeutic Services

What therapy goals do you have for this youth?

Previous Mental Health Care
Year Services began; Timespan, Name of Provider, Reason services began

Current Mental Health Care
Year Services began; Timespan, Name of Provider, Reason services began

Has this youth 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

Has this youth ever made mention of suicide, homicide, or engaged in self-injurious behavior (cutting)? If yes, Please share specifics

Please share any experience(s) this youth has had with physical, sexual, emotional abuse, neglect or trauma

FAMILY MAKE-UP

Current Care Giver 1 (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Current Care Giver 2 (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Mother (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Father (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Step Mother (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Step Father (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Siblings (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Other 1(Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Other 2 (Name, age, Living/Deceased Date, Occupation/Grade Level, Place of Employ)

Family Group with whom Youth Currently Lives with

OUT OF HOME RESIDENTIAL HISTORY

(Care Provider, Place of Residence, Date Began, Date Ended, Reason for Placement)

EDUCATIONAL HISTORY

(Schools, Grade, Date Began, Date Ended, Reason for Ending/Transfer)

EDUCATIONAL CHALLENGES

Briefly discuss any concerns you have regarding this youth's academic functioning and behavior

LEGAL HISTORY

Briefly discuss any previous/current legal history, including arrest, detentions, and litigation for this youth

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 for youth

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

Please share any concerns you might have regarding this youth's substance usage

MEDICAL HISTORY

Briefly discuss current major medical/physical concerns for youth

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

Please list any Significant Past Injuries, Illnesses, or Surgeries

Current/Past Medications

Please share any concerns you have regarding your child's behavior, emotional states-mood, attention, academics, general functioning, relationship challenges, etc.

PLEASE GIVE AN OVERALL DESCRIPTION OF YOUR CHILD

AVAILABILITY

(please check ALL that apply)

Monday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐
Tuesday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐
Wednesday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐
Thursday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐
Friday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐
Saturday	☐	Morning (8am-11)	☐	Afternoon (12-4pm)	☐	Evening (after 5pm)	☐

FINANCES and INSURANCE

Client's Name

Client's Birthdate

Client's Insurance Member ID Number

Policy Holder's Name

Client's Relationships To Policy Holder

Policy Holder's SSN

Insurance Policy Group Number

Provider Relations/Pre-Certification Number on Back of Insurance Card

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

Number of Dependents for Primary Caregiver

SELF PAY

☐ I prefer to not use any insurance and will pay for services directly.

SIGNATURE

Please include your initials next to the statements below indicating your understanding that:

_____ You are authorizing psychological services for the above named client to be rendered by Hope Haven Psychological Resource, LLC

_____ As the authorizing signature, you assume sole financial responsibility for services rendered.

_____ You are personally responsible for payment of all appointments not advance cancelled within 24 hours

SIGNATURE

I authorize psychological services for the above named client to be rendered by Hope Haven Psychological Resource, LLC

Client Signature (First MI Last) Electronic Signature ☐	Date	Parent/Guardian/Representative Sign. Electronic Signature ☐	Date
Witness/Psychological Prof. Signature Electronic Signature ☐	Date	Legal Authority of Representative	

Print: Psychological Professional Name and Credentials

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

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Family Counseling Initial Parenting Form

Your Name:

Relationship to Child(ren):

Partner's Name:

Child(ren) Names:

Date:

How would you describe how you parent?

How does your child(ren) respond to your parenting style?

How would you describe your co-parents parenting style?

What is your strength as a parent?

How does your child(ren) respond to your co-parents parenting style?

How would you describe how you were parented?

How did you respond to this type of parenting?

What are your goals/hopes for therapy with regards to your child(ren)/family?

What are some areas of growth you have with regards to parenting (what could you work on)?

How could you use counseling to support you in this growth area?

What is your concern with regards to your family?

How have you contributed to this concern (productive and not-so-productive ways)?

Name three things that you know you could do different regarding this concern?

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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

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

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

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

Print: Psychological Prof Name and Credentials

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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 you 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 Heath 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

Client Name | Date of Birth | Age

Address | City/State | Zip Code

Home Phone

Permission to leave message at this number (with the person answering the phone, answering machine and/or voice mail) ☐ YES ☐ NO

Work Phone

Permission to leave message at this number (with the person answering the phone, answering machine and/or voice mail) ☐ YES ☐ NO

If Client is a minor-aged child:

Parent/Legal Guardian/Representative | Relationship to Child

Home/Additional Contact Phone

Permission to leave message at this number (as stated above) ☐ YES ☐ NO

Work Phone

Permission to leave message at this Number (as stated above) ☐ YES ☐ NO

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
(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.

Client Signature (First MI Last) Date Parent/Guardian/Representative Sign. Date
Electronic Signature ☐ Electronic Signature ☐

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

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.

Client Signature (First MI Last) Date Parent/Guardian/Representative Sign. Date
Electronic Signature ☐ Electronic Signature ☐

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

Print: Psychological Professional Name and Credentials

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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 parities 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 | Date | Parent/Guardian/Representative Sign. | Date

Electronic Signature ☐ | Electronic Signature ☐

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

Electronic Signature ☐

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) incompliance with and pursuant of the Health Insurance Portability and Accountability Act (HIPAA)

I. Signatures

Client Name (First MI 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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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:_____
(If different from previous name)

Text Number: (____)_____

Client/Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date: _____

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

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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

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	☐ 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

☐ 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.

Client Signature (First MI Last) Electronic Signature ☐	Date	Parent/Guardian/Representative Sign. Electronic Signature ☐	Date
Witness/Psychological Prof. Signature Electronic Signature ☐	Date	Legal Authority of Representative	

Print: Psychological Professional Name and Credentials

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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: Benetta E. Johnson, Ph.D., HSPP

☐ Obtain Information from:

Benetta E. Johnson, Ph.D., HSPP, Licensed Counseling Psychologist, Supervisor

Name/Agency

5610 Crawfordsville Road	701	Indianapolis, Indiana
Address	Apt#/Suites/Lot	City/State

46224	317-241-4673	317-241-0201
Zip Code	Phone Number	Fax Number

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:

☒ 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

☒ 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.

Client Signature (First MI Last) Electronic Signature ☐	Date	Parent/Guardian/Representative Sign. Electronic Signature ☐	Date
Witness/Psychological Prof. Signature Electronic Signature ☐	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 _____ (Date (*month, day, year*)). 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 (Name of provider) will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Signature of member

Signature of member

☐ **Member declined to participate**

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		

Allergies to medications:

Current diagnosis:

Comments:

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

☐ **Medication log attached**

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		

Allergies to medications:

Current diagnosis:

Comments:

Please provide the following information regarding (*Member name*)	2. Is another appointment required? ☐ Yes ☐ No	If yes, date and time scheduled ☐ AM ☐ PM
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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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:_____