



## 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](http://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)

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

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**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)

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

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**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)

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### **EDUCATIONAL HISTORY**

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

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### **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	<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"/>

**FINANCES and INSURANCE**

Client's Name	<input type="text"/>	Client's Birthdate	<input type="text"/>
Client's Insurance Member ID Number	<input type="text"/>	Policy Holder's Name	<input type="text"/>
Client's Relationships To Policy Holder	<input type="text"/>	Policy Holder's SSN	<input type="text"/>
Insurance Policy Group Number	<input type="text"/>		

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

Revised - 1102

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



# 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: \_\_\_\_\_

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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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## 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

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.

<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

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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 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**

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

--	--	--

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

--

Print: Psychological Prof Name and Credentials

# HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

11

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



# HOPE HAVEN PSYCHOLOGICAL RESOURCE, LLC

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

### **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 disabled 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**

COPY

Client Name (First MI Last)

COPY

Date of Birth

COPY

Age

COPY

Client Signature

Electronic Signature ☐

COPY

Date

COPY

Parent/Guardian/Representative Sign.

Electronic Signature ☐

COPY

Date

COPY

Witness/Psychological Prof. Signature

Electronic Signature ☐

COPY

Date

COPY

Legal Authority of Representative

COPY

Print: Psychological Prof Name and Credentials

COPY





## 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](http://www.hopehavenpsych.org)

### **SCHOOL-BASED FEE POLICIES AND PROCEDURES (HOOSIER HEALTHWISE)**

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

- ☐ 1. The sliding fee for Individual Therapy is \$40.00-75.00 per session without insurance (Based on Income and Number of Dependents). Group sessions are less and based on the length of the sessions. If your insurance were to lapse this is the fee range 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 your child's therapist 24 hours in advance, informing the therapist of your child's school absence.
- ☐ 6. If you or your child misses **THREE** consecutive appointments without 24 hour notice your child's therapy services may be terminated.
- ☐ 7. Please notify *your therapist* if your contact information has changed, being sure to inform the office of specific instructions regarding how to contact you.
- ☐ 8. Please be available and on time for your appointment. Your child's therapist will not wait more than 15 minutes for your child if they are not at school. Your child's therapist will not wait more than 15 minutes for any scheduled office based appointments. If you or your child are late, the session will only include the remaining portion of the session that is available.

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

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



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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION  
(PHI)**

<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient Name	Date of Birth	Age	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address	Apt#/Suites/Lot	City/State	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
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

<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	Apt#/Suites/Lot	City/State
<input type="text"/>	<input type="text"/>	<input type="text"/>
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: **IMSA WEST**

**The Protected Health Information to be Released/Disclosed:**

<input type="checkbox"/> Entire Records	<input checked="" type="checkbox"/> Attended Sessions	<input checked="" type="checkbox"/> Treatment Plans
<input checked="" type="checkbox"/> Initial Evaluation	<input checked="" type="checkbox"/> Psychological Report/Testing	<input checked="" type="checkbox"/> Treatment Summary
<input type="checkbox"/> Diagnoses	<input checked="" type="checkbox"/> School Behavior Records	<input checked="" type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychotherapy Notes	<input checked="" type="checkbox"/> Medications/Medical History	<input type="checkbox"/> Billing Records

☒ Other:

Safety concerns regarding self and others within IMSA North  
( See Notice of Policies and Practices)

**Protected Health**

**Information to be Released/Disclosed**

<input checked="" type="checkbox"/> Verbally	<input checked="" type="checkbox"/> U.S. Postal Service	<input checked="" type="checkbox"/> Fax	<input checked="" type="checkbox"/> Photocopy
<input checked="" type="checkbox"/> Other	<input type="text"/>		

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  (Include a 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



## HOPE HAVEN PSYCHOLOGICAL RESOURCE

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

### **AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

<input type="text"/>		<input type="text"/>	<input type="text"/>
Patient Name		Date of Birth	Age
<input type="text"/>		<input type="text"/>	<input type="text"/>
Address		Apt#/Suites/Lot	City/State
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

<input type="text" value="5610 Crawfordsville Road"/>		<input type="text" value="200"/>	<input type="text" value="Indianapolis, Indiana"/>
Address		Apt#/Suites/Lot	City/State
<input type="text" value="46224"/>	<input type="text" value="317-241-4673"/>	<input type="text" value="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:**

<input checked="" type="checkbox"/> Entire Records	<input checked="" type="checkbox"/> Attended Sessions	<input checked="" type="checkbox"/> Treatment Plans
<input checked="" type="checkbox"/> Initial Evaluation	<input checked="" type="checkbox"/> Psychological Report/Testing	<input checked="" type="checkbox"/> Treatment Summary
<input checked="" type="checkbox"/> Diagnoses	<input checked="" type="checkbox"/> School Behavior Records	<input checked="" type="checkbox"/> Discharge Summary
<input checked="" type="checkbox"/> Psychotherapy Notes	<input checked="" type="checkbox"/> Medications/Medical History	<input checked="" type="checkbox"/> Billing Records
<input type="checkbox"/> Other:	<input type="text"/>	

#### **Protected Health Information to be Released/Disclosed**

<input checked="" type="checkbox"/> Verbally	<input type="checkbox"/> U.S. Postal Service	<input checked="" type="checkbox"/> Fax	<input checked="" type="checkbox"/> Photocopy
<input checked="" type="checkbox"/> Other	<input type="text" value="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 <b>CLIENTS INFO</b>		Date (month, day, year) <b>— DATE —</b>	
Name of member <b>1</b>		Date of birth (month, day, year) <b>CLIENT INFO</b>	
Health care provider <b>PRIMARY CARE DOCTORS INFO</b>		Behavioral health provider Hope Haven Psychological Resource, LLC	
Address (number and street)		Address (number and street) 5610 Crawfordsville Road, Suite 701	
City, state, ZIP code		City, state, ZIP code Indianapolis, Indiana 46224	
Telephone number ( )	Fax number ( 1 )	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](http://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 **PLEASE ALLOW TWO (2) YEARS FROM TODAY**. 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

by the recipient and may no longer be protected.

Signature of member

**SIGN HERE IF AGREE**

Signature of member

**SIGN HERE IF DECLINE**☐ **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

☐ Yes ☐ No☐ 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)

**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.

<b>Insurer patient identification number</b>		<b>Date (month, day, year)</b>	
<b>Name of member</b>		<b>Date of birth (month, day, year)</b>	
<b>Health care provider</b>		Behavioral health provider <b>Hope Haven Psychological Resource, LLC</b>	
<b>Address (number and street)</b>		Address (number and street) <b>5610 Crawfordsville Road, Suite 200</b>	
<b>City, state, ZIP code</b>		City, state, ZIP code <b>Indianapolis, Indiana 46224</b>	
<b>Telephone number</b> (      )	<b>Fax number</b> (      )	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](http://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

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	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

☐ Yes ☐ No☐ 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)



# HOPE HAVEN PSYCHOLOGICAL RESOURCE

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[www.hopehavenpsych.org](http://www.hopehavenpsych.org)

## **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)

